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

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

OCTOBER-DECEMBER 1998

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CITE AS

50 Van Natta ____ (1998)

In the Matter of the Compensation of
STEVEN M. ANDERKO, Claimant
WCB Case No. TP-98006
THIRD PARTY DISTRIBUTION ORDER
Powers, McCulloch, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney
David B. Hatton, Department of Justice

Reviewed by Board Members Haynes and Bock.

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds from a third party settlement. *See* ORS 656.593(3). Specifically, claimant contends that the SAIF Corporation should reimburse claimant for a share of his attorney fees ($59,705.12, which is 1/3 of the $179,113.37 previously provided to SAIF as reimbursement for its third party lien). We conclude that a distribution in which SAIF receives reimbursement for its claim costs from the remaining balance of settlement proceeds would be "just and proper."

FINDINGS OF FACT

On August 16, 1995, claimant was injured during a motor vehicle accident while performing his job. After a claim was filed, SAIF accepted it for "closed head injury with intracranial hemorrhage consistent with diffuse axonal injury." Thereafter, claimant filed a cause of action for negligence against the third party. On May 7, 1998, SAIF informed claimant's attorney of its lien for $179,115.37 ($133,982.18 for medical costs, $16,086.03 for wage loss, $10,256.57 for vocational rehabilitation, $17,790.59 for permanent disability, and $1,000 for future medical treatment).

On May 15, 1998, claimant settled his third party claim for $440,000. SAIF approved the settlement. Claimant's attorney received $146,666.67 as an attorney fee, as well as $9,193.85 for litigation costs. From the remaining balance of $284,139.48, claimant paid SAIF $179,115.37 with the proviso that he would challenge that the amount was not a "just and proper" distribution. Claimant retained the remaining $105,024.11 as his "undisputed" share of the settlement proceeds. On July 16, 1998, claimant petitioned the Board for resolution of the parties' dispute.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The paying agency has a lien against the worker's cause of action, which lien shall be preferred to all claims except the cost of recovering such damages. ORS 656.580(2). The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury allegedly as a result of the negligence of a third party. The claim was accepted by SAIF, which provided compensation in excess of $179,000. SAIF is therefore a paying agency under ORS 656.576. When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable.

Because claimant settled his third party claim and SAIF ultimately approved the settlement, the distribution of proceeds is governed by ORS 656.593(3). SAIF is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that claimant receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); *Estate of Troy Vance v. Williams*, 84 Or App 616, 619-20 (1987). The amounts referred to in ORS 656.593(1) and (2) pertain to attorney fees, litigation expenses, and claimant's statutory 1/3 share of the balance. Because the parties cannot agree as to what constitutes a "just and proper distribution," the conflict shall be resolved by the Board.

In determining a "just and proper" distribution, we judge each case based on its own merits. *Urness v. Liberty Northwest*, 130 Or App 454, 458 (1994). Because "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. *Id.*

Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination is based on the merits of the case. *Id.* In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1).

Here, claimant contends that SAIF should pay for a portion of the attorney fees out of its statutory share of the settlement to "result in more adequate compensation to [claimant] based on the seriousness of his injuries." In particular, claimant contends that SAIF should pay $59,705.12, or one-third of its total statutory share of the third party settlement.

Yet, claimant does not contest SAIF's representation that its asserted lien for its actual and future claim expenditures were for "compensation" attributable to the accepted injury claim.[1] Moreover, claimant has not challenged the payment of those actual claim costs ($178,115.37 of the $179,115.37 asserted lien - only $1,000 was claimed for future medical costs). Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. *Jack S. Vogel*, 47 Van Natta 406 (1995).

Furthermore, as we have discussed in previous cases, there is no express statutory authority supporting claimant's position that the paying agency's lien should be reduced for the recovery of attorney fees. *See, e.g., Dennis Youngstrom*, 47 Van Natta 1622, 1623 (1995). Rather, where we find the statutory distribution scheme of ORS 656.593(1) to represent a "just and proper" distribution of settlement proceeds, we have followed that method in determining that attorney fees and litigation costs are initially payable from the third party recovery prior to the distribution of the claimant's one-third statutory share and, eventually, the attachment of the carrier's third party lien. *Id.* Thereafter, any remaining balance is retained by the claimant. *Id.*

Here, nearly all of SAIF's asserted and uncontested lien is composed of actual claim expenditures. Moreover, all of those costs (actual or projected) constitute "compensation" that has been or will be provided to claimant. Under such circumstances, we find it "just and proper" for SAIF to receive full reimbursement for these expenses.[2] *See* ORS 656.593(3); *Norman H. Perkins*, 47 Van Natta 488, 490 (1995).

Accordingly, consistent with the aforementioned reasoning, claimant's petition for re-apportionment of the third party settlement proceeds is denied.

IT IS SO ORDERED.

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[1] "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to OSR Chapter 656. ORS 656.005(8).

[2] Were we to follow claimant's proposed distribution, his share of the settlement proceeds would increase from $105,024.11 to $164,729.23, while SAIF's share would decrease from $179,113.37 to $119,408.25. Inasmuch as claimant's share of the third party recovery is a supplement to the workers' compensation benefits that he has either already or will receive, we do not consider his proposal to reduce by one-third SAIF's unchallenged lien for primarily actual claim expenditures to represent a "just and proper" distribution of proceeds from the third party settlement.

In the Matter of the Compensation of
JERRY R. BAUGH, Claimant
WCB Case No. 97-09464
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its partial denial as an invalid "pre-closure" denial of claimant's right knee condition; and (2) awarded claimant an assessed attorney fee. On review, the issues are the propriety of SAIF's denial and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Denial

In reaching his conclusion that SAIF's denial was an impermissible "pre-closure" denial, the ALJ relied on our decision in *Elaine M. Borgelt*, 50 Van Natta 143 (1998). In *Borgelt*, we held that, in order for a pre-closure denial under ORS 656.262(7)(b) to be valid, the carrier must first expressly accept a "combined condition." Subsequent to the ALJ's order, however, we disavowed our decisions in *Borgelt* and in *Robin W. Spivey*, 48 Van Natta 2363 (1996).

In *Tracey A. Blamires*, 50 Van Natta 1793 (1998), we revisited the "pre-closure" denial case law established by the aforementioned cases. We noted that, long before the applicable 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 preempting the resolution of an issue involved in determining extent of disability. However, we further noted that the statutory changes enacted since *Roller* contemplated precisely the procedure that "pre-closure" partial denials of combined conditions effectuate.

Specifically, in *Blamires*, we held that, 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 that a denied condition is found to be compensable post-closure. Moreover, we found that 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." Accordingly, we concluded that, under the current statutory scheme, "pre-closure" partial denials will not have the effect of circumventing ordinary claim closure procedures because those procedures themselves have been revised.

Consequently, after considering the text and context of the recent enactments,[1] we concluded in *Blamires* that the legislature has expressly endorsed the issuance of "pre-closure" denials, insofar as they apply to a "combined condition" context. Under the circumstances, we concluded that the holding in the *Spivey* line of cases (that a carrier must accept a combined condition before availing itself of the pre-closure denial procedure under ORS 656.262(7)(b)), imposed a requirement not expressly mandated by the statute. Therefore, consistent with the statutory scheme, we disavowed *Spivey*.

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[1] We also noted that, subsequent to the court's decision in *United Airlines, Inc. v. Brown*, 127 Or App 253 (1994), the legislature amended ORS 656.005(7)(a)(B). We concluded that the amendments to the statute indicated an intent to overrule the court's decision and 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 causes of the combined condition.

Finally, we held in *Blamires* 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 need for treatment, the carrier is authorized to issue a denial. The denial may be issued when the accepted injury is no longer the major cause of the worker's combined condition. Accordingly, because SAIF's denial in the present case was issued under such circumstances, we proceed to the merits.

Dr. Schilperoort examined claimant on SAIF's behalf and reported that, prior to the compensable injury, claimant had injured his right knee, had undergone surgeries on the knee, and had been diagnosed with arthritis in the knee. Dr. Schilperoort opined that claimant's preexisting degenerative condition had combined with his compensable knee strain. (Ex. 18-7). Dr. Neumann, medical arbiter, also agreed that claimant had a preexisting condition. (Ex. 29). After reviewing the medical record, we conclude that claimant has a "combined condition" involving his preexisting degenerative condition and surgeries and his subsequent knee strain.

Pursuant to 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, Dr. Schilperoort opined that claimant's compensable 1997 knee strain injury combined with the preexisting condition. While Dr. Schilperoort found that claimant's sprain probably was the "originating cause for the need for seeking treatment," he was not certain whether the sprain was a "symptomatic flare of a degenerative condition or was causative in re-injury of the right medial meniscus...". (Ex. 18-7). Dr. Schilperoort later reported that claimant's knee sprain resolved six weeks after the injury, and "the pre-existent underlying degenerative condition then becomes the major contributing cause of disability and need for treatment." (Ex. 21-2, 27).

Dr. James, claimant's treating doctor, initially concurred with Dr. Schilperoort's findings and opinion. (Ex. 26). However, Dr. James subsequently reported that he disagreed with a portion of the opinion and believed that claimant had a derangement of the knee which was caused, in major part, by the compensable injury. (Ex. 28-1).

A medical arbiter, Dr. Neumann, reported that claimant's right knee strain was medically stationary, but any findings of impairment were due to the preexisting condition, rather than to the accepted right knee strain. (Ex. 29).

After reviewing the expert medical evidence, we conclude that claimant has failed to prove that his accepted knee strain remains the major contributing cause of his current disability or need for treatment. Although Dr. James recited the proper words, his opinion does not satisfy the *Dietz v. Ramuda* standard. Specifically, we find that Dr. James failed to evaluate the relative contribution of claimant's preexisting degenerative condition and prior surgeries. Nor does Dr. James' opinion explain why claimant's work injury was the primary cause when compared to the preexisting conditions. Finally, we conclude that the remaining medical opinions do not establish compensability.

Consequently, we conclude that claimant's accepted strain injuries are no longer the major contributing cause of his disability and/or need for treatment. We therefore reinstate SAIF's partial denial.

ORDER

The ALJ's order dated March 17, 1998 is reversed. The SAIF Corporation's denial dated October 14, 1997 is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
JOHN HAGER, Claimant
WCB Case No. 97-08804
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's occupational disease clam for a bilateral knee condition; and (2) awarded a $5,000 assessed attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

To establish a compensable occupational disease claim for his bilateral knee condition, claimant must prove that employment conditions were the major contributing cause of the onset or pathological worsening of the condition. *See* ORS 656.802(2)(a) and (b). A finding of "major" causation requires that the work activity contribute more to the claimed condition than all other causes, explanations, or exposures combined. *See McGarrah v. SAIF*, 296 Or 145, 146 (1983); *Dethlefs v. Hyster Co.*, 295 Or 309-310 (1983). Pursuant to ORS 656.802(2)(e), preexisting conditions are deemed to be causes in determining the major contributing cause.[1]

Here, the ALJ inferred the requisite major causal relationship from the opinion of Dr. Lubcke, the insurer's medical examiner. On review, the insurer challenges the ALJ's rationale and contends that the record does not satisfy claimant's burden of establishing a compensable occupational disease claim by a preponderance of the evidence. We agree.

In a January 20, 1998 opinion letter, Dr. Lubcke attributed claimant's knee condition to repetitive stress osteochondritis of the kneecaps, secondary to excessively tight hip flexors and tensor fascia lata (TFL), the latter being a broad fibrous band that extends from the knee up into the hip/ilium area of the low back. In that same letter, Dr. Lubcke opined as follows:

> "The kneecap glides in the femoral groove through the gait cycle. As the postural function of the foot, knee, and hip changes due to tight hip flexors and the tensor fascia lata, the patient toes-out and develops a high stress gait pattern. This produces microtrauma and will result in an inflammatory component. An inclined or declined plane makes the shock absorption mechanism of gait more demanding and also less forgiving. The constant walking, therefore, on an inclined or declined plane would be the mechanism which produced the stress, which in turn caused the inflammatory reaction.
>
> "* * * *
>
> "The patient is significantly overweight and has an abnormal gait with pes planus and toe-out. The increased stress produced from his overweight condition can be a significant causative factor producing the repetitive stress osteochondritis condition of the knee cap. The increased walking he performed with his job may have simply been the 'straw that broke the camel's back'.

---

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

"* * * *

"Based on his history, I do not note that there was any primary event of cause. His job likely required exercise which was much more extensive than he was used to on an inclined and declined plane. If he was not overweight, was in condition, and was 20 years old, it is not probable that this would have produced an injury."

Drs. Lubcke and Goldberg subsequently concurred with the following prepared statement on January 27, 1998:

"You believe that [claimant's] condition of osteochondritis of the kneecaps was caused by a combination of this tight Tensor Fascia Lata (TFL), his obesity, and his walking activities as a security guard[.] The TFL is an idiopathic condition which was not caused by his workplace exposure[.] In your opinion, [claimant] had extremely tight hip flexors and TFL, which predisposed him to develop symptoms of osteochondritis when he walked uphill in the course of his employment[.] You believe that [claimant] would not have developed this condition were it not for this predisposition. As a corollary, if someone of his age engaged in the same activities as [claimant] described, such a person would probably not have developed osteochondritis and needed medical treatment[.] Therefore, you believe the reported physical activities described by [claimant] were not sufficient in and of themselves to cause his need for medical treatment in the absence of the predisposing TFL, as well as his obesity[.] As such, you do not believe his work activities were the major contributing cause of his condition and need for treatment."

In a subsequent March 19, 1998 deposition, Dr. Lubcke opined that claimant's repetitive stress osteochondritis was an inflammatory condition of the undersurface of the patella "brought on by the repetitive stress of walking." Dr. Lubcke further opined that claimant's work activity, altered gait and other predisposing factors were all significant contributors to the knee condition. Finally, Dr. Lubcke engaged in the following colloquy:

"Q. So it's those three factors that you are looking at: his weight, altered gait, and his employment contribution?

"A. Right.

"Q. Now, you have previously given the opinion * * * that work was not the major cause within those three factors. Is that still your opinion?

"A. Yes.

"Q. * * * Tell me why you conclude that work is not the major cause.

"A. I conclude that work is not the major cause because the abnormalities that I found in his gait and his weight were very significant. Because in a normal, perhaps younger individual that is not overweight and does not have [an abnormal] gait, I wouldn't expect to see the same type of knee pain or condition produced.

"Q. Do you have an opinion as to whether work was the major cause of the symptoms that he suffered?

"A. I'm not sure that I understand your question. That --

"Q. He's going through life for however many years without any problems, apparently, and then he gets this job that he's doing, in your words, "for a prolonged period of time," and he begins to suffer symptoms. So I realize all three of the things are going on at once: his weight and altered gait and employment. * * * [O]f those three things, what I'm asking is whether his work was the major cause of the symptoms.

"A. The job that he was engaged in was the event that then triggered the symptoms, yes.

"* * * *

"Q. When he's complaining about pain not just in the knee itself but up and down the leg in the area of the knee, is that muscle pain?

"A. Quite probably.

"Q. And would that muscle pain be caused in major part by his at-work exposure?

"A. Yes.

"* * * *

"A. When he feels the pain created by this condition, what is going on in the knee biomechanically that tells him, "Hey, I hurt"? Is there some change there?

"A. There's an inflammatory condition [that] his proprioceptors are receiving as pain; consequently, he knows there is a problem[.]

"Q. That inflammation is in response to walking up and down these inclines, correct?

"A. Yes.

"Q. That's what's causing the inflammation?

"A. The walking up and down the inclines in concert with all of the other events happening in his body.

"* * * *

"Q. The change that's occurring for the first time because he's walking up and down these inclines, now he's got some muscle tightness, and that's creating inflammation in that area that had not been there previously. That's a change?

"A. Yes. The walking up and down the inclined plane was the trigger event."

The ALJ inferred a major contributing cause relationship from this medical record, even though neither doctor expressly identified claimant's work activity as the major contributing cause. *See Liberty Northwest Ins. Corp. v. Cross*, 109 Or App 109, 111-13 (1991), *rev den* 312 Or 676 (the statute does not require that medical evidence consist of a specific incantation or that it mimic the statutory language). We do not agree that such an inference is supported by the record.

Dr. Lubcke repeatedly stated that claimant's work activity was not the major contributing cause of his knee condition, and Dr. Goldberg concurred in that position. Dr. Lubcke's characterization of claimant's work activity as the "trigger" event merely establishes that work was a precipitating cause. The fact that a work activity caused or precipitated a claimant's condition does not necessarily mean that work was the major contributing cause of the condition. *See Robinson v. SAIF Corp.*, 147 Or App 157 (1997); *Dietz v. Ramuda*, 130 Or App. 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Finally, to the extent Dr. Lubcke's opinion might support an inference of a major causal relationship, that inference is unpersuasive because it conflicts with his express opinion that the work is not the major contributing cause of the knee condition.

For these reasons, we disagree with the ALJ's conclusion that the opinion of Dr. Lubcke establishes that claimant's work is the major contributing cause of his knee condition. Furthermore, given the complexity of the medical issues in this case, claimant cannot establish compensability of his claim without supporting medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). There is no other medical opinion in the record supporting compensability of claimant's occupational disease claim. Consequently, we reverse the ALJ's decision to set aside the insurer's denial. In light of this conclusion, claimant is not entitled to the assessed attorney fee awarded at hearing.

ORDER

The ALJ's order dated May 18, 1998 is reversed in part and affirmed in part. The insurer's October 22, 1997 denial is reinstated and upheld. The ALJ's $5,000 assessed attorney fee award is reversed. The ALJ's order is otherwise affirmed.

In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 97-0523M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer, through Sedgwick of Oregon, its claims processing agent, requested reconsideration of our December 11, 1997 order, as reconsidered January 21, 1998 and March 19, 1998, in which we ultimately authorized reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery. In its latest request for reconsideration, Sedgwick stated that, although it was not denying compensability at this time, it was requesting Director review of the reasonableness and necessity of the low back surgeries performed by Dr. Treible, claimant's treating surgeon. Subsequently, Sedgwick submitted a copy of its May 28, 1998 letter to the Director requesting review and copies of several supporting documents.

In order to allow sufficient time to consider the motion for reconsideration, we abated our prior orders and allowed claimant time to respond to Sedgwick's motion. After receiving the parties' responses, we issued a Second Order of Abatement / Order of Postponement on June 29, 1998. In that order, we concluded that the own motion matter must remain abated pending resolution of the litigation regarding the reasonableness and necessity of the surgeries performed by Dr. Treible.

By letter dated September 18, 1998, the attorney for Sedgwick advised the Board that the parties have reached a "tentative settlement," which apparently includes their pending dispute before the Director. As a result, Sedgwick withdraws its latest request for reconsideration and requests that we republish our prior orders.

Given the fact that Sedgwick has withdrawn its latest request for reconsideration, we republish our December 11, 1997 order, as reconsidered January 21, 1998 and March 19, 1998, effective this date. As stated above, in those orders, we ultimately authorized reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery. 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
KRISTOFER C. HECKENBERG, Claimant
WCB Case No. 97-03513
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) found that the correct rate of claimant's temporary disability benefits was based on an average weekly wage of $526.40; and (2) declined to award penalties and attorney fees. On review, the issues are rate of temporary disability, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability Benefits

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

SAIF initially based claimant's temporary disability rate on an average weekly wage of $545.51. SAIF then recalculated the average weekly wage as $526.40. Subsequently, SAIF again recalculated claimant's average weekly wage as $506. The ALJ found that the correct temporary disability rate was based on an average weekly wage of $526.40. On review, SAIF argues that the correct average weekly wage upon which to base claimant's temporary disability benefits is $506.

On review, claimant argues that the ALJ erred in determining that his gross wages, upon which to calculate his temporary disability rate, were $22,530.[1] Specifically, claimant argues that the last wage entry, on page 4 of Exhibit 7 (the employer's payroll records for claimant), in the amount of $240 should be included in claimant's gross wages for a total of $22,770.

Pursuant to *former* OAR 436-60-025(5)(a), the 52 weeks prior to the date of injury are used to determine the worker's average weekly wage. Where, as here, there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, only the actual weeks under the wage earning agreement at the time of injury are used. *Id.*

The last entry on Exhibit 7, page 4 gives gross wages of $240 for a one week period after October 15, 1995, but before November 11, 1995. Claimant's injury occurred on October 12, 1995. Thus, based on this record, the $240 appears to be for a period after the date of the injury. Since the administrative rule indicates that only wages prior to the injury are used, claimant has not established that the $240 should be included in the gross wages for the relevant period.

SAIF argues that claimant's gross wages should be divided by 45 weeks. Claimant argues that the gross wage figure should be divided by 42.4 weeks as found by the ALJ. We agree with the ALJ that the preponderance of the evidence in the record establishes that the change in the wage earning agreement occurred on December 16, 1994. On that date, claimant's wage was increased from $18 an hour to $20 an hour. Thus, we find that the correct number of weeks prior to the injury under the new wage agreement is 42.4. In reaching this conclusion, we rely on the employer's payroll records contained in Exhibit 7. The pay period prior to the wage change is the period apparently ending December 15, 1994. That pay period indicates that the wage rate was $18. The pay period for January 15, 1995, which indicates that claimant was paid for a 4 week period, gives a rate of $20. Based on this

[1] SAIF also argues that the gross wages are $22,770. However, as explained in this order, the record supports the finding that the gross wages for the relevant period are $22,530 as the ALJ concluded.

evidence, we find that the new wage rate went into effect after the pay period ending December 15, 1994. Thus, we find that the new rate took effect on December 16, 1994.[2] Accordingly, we find that the rate change took effect on December 16, 1994 and that, consequently, a 42.4 week period prior to the injury is used to determine the weekly wage.

Penalties Under ORS 656.262(11) / Attorney Fee Under ORS 656.382(1)

We adopt the ALJ's conclusion and reasoning concerning the penalty issue with the following supplementation.

Because claimant's temporary disability benefits have all apparently been paid at a rate higher than the rate claimant is entitled to, there is no evidence of amounts then due upon which to base a penalty or an attorney fee for the unreasonable resistance to the payment of compensation. Under such circumstances, claimant has not established entitlement to a penalty pursuant to ORS 656.262(11) or an attorney fee under ORS 656.382(1).

Out-of-Compensation Attorney Fee

Finally, claimant argues that the ALJ erred in not awarding an out-of-compensation attorney fee. Specifically, claimant argues that SAIF recalculated claimant's time loss rate again prior to hearing based on an average weekly wage of $506[3] and that because the ALJ found that the average weekly wage should instead be $526.40, the ALJ's order resulted in increased compensation and claimant was entitled to an out-of-compensation attorney fee. We agree.

Claimant was awarded temporary total disability benefits from December 12, 1995 through March 26, 1996 and temporary partial disability benefits from March 27, 1996 through September 17, 1996 by a Notice of Closure. The temporary disability award was affirmed by an Order on Reconsideration. The temporary disability benefits were apparently paid by SAIF based on an incorrect average weekly wage of *$545.51*. SAIF subsequently recalculated the average weekly wage as *$526.40* and asserted an overpayment based on the difference between the incorrect average weekly wage of $545.51 and the correct average weekly wage of $526.40. Part of the overpayment was also based on the fact that temporary disability benefits had been paid beyond the medically stationary date. (Ex. 25A).

Prior to hearing, SAIF again recalculated the temporary disability rate to a lower figure based on an average weekly wage of *$506*. As a result of the hearing, the ALJ found that the proper average weekly wage was $526.40. Thus, we agree with claimant that the ALJ's order technically resulted in an increase in compensation.[4] To the extent that the ALJ's order awarded additional compensation for temporary disability, claimant is entitled to an approved fee of 25 percent of the increased compensation, not to exceed $1,050.[5] ORS 656.386(2); OAR 438-015-0045. Because the temporary disability award has apparently 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 on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995), *rev den* 322 Or 645 (1996).

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[2] We note that Exhibit 47, which is a "Proposed and Final Order on Disputed Weekly Wage for Computing the Temporary Disability Rate," also indicates that the new wage rate of $20 an hour took effect on December 16, 1994.

[3] In finding that claimant's average weekly wage had been recalculated to $506 prior to the hearing, we rely on SAIF's acknowledgment of that fact in its respondent's brief and its argument that it correctly recalculated claimant's average weekly wage at $506.

[4] Although SAIF apparently paid all of claimant's temporary disability benefits based on an average weekly wage of $545.51, it subsequently recalculated the rate of temporary disability benefits based on an average weekly wage of $526.40 and asserted the right to an overpayment. Subsequently, SAIF again recalculated claimant's benefits based on an average weekly wage of $506. Thus, by finding that claimant's rate of temporary disability should be based on an average weekly wage of $526.40, the ALJ's order technically resulted in an *increase* in claimant's compensation.

[5] We note that "out-of-compensation" attorney fees are not subject to offset. OAR 438-015-0085(2); *Weyerhaeuser Co. v. Sheldon*, 86 Or App 46 (1987).

Because SAIF argued on review that claimant's temporary disability rate should be based on an average weekly wage of $506 and because we have not disallowed or reduced claimant's compensation, (*i.e.*, we have affirmed the ALJ's order finding that the correct rate should be based on an average weekly wage of $526.40), claimant's attorney is entitled to an attorney fee for services on review pursuant to 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 $200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 4, 1998, as reconsidered April 20, 1998, is affirmed in part and modified in part. To the extent that the ALJ's order resulted in an increase in claimant's temporary total disability benefits, claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation awarded by the ALJ's order, not to exceed $1,050. In the event that the temporary disability benefits have already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk.* For services on review regarding SAIF's contention that claimant's average weekly wage should be $506, claimant's attorney is awarded a $200 attorney fee, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
BARBARA J. LLOYD, Claimant
WCB Case No. 94-00752
SECOND ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, Williamson, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Kmart Corp. v. Lloyd,* 155 Or App 301 (1998). Based on the retroactive application of ORS 656.262(10), as amended by the 1997 legislature, the court has reversed our prior order, *Barbara J. Lloyd,* 49 Van Natta 649 (1997), which had held that the self-insured employer was precluded it from contesting compensability of claimant's degenerative right knee condition because it had failed to appeal a Determination Order award for that condition.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for his finding that the 1986 left foot injury was the major contributing cause of claimant's current right knee condition.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her left foot in April 1986 when she stepped in a hole at work. In November 1986, claimant began experiencing right knee pain and was eventually found to have permanent impairment of her right knee due to "medial compartment degenerative changes and chondromalacia." In June 1987, the cartilage in claimant's right knee was shaved. The claim was closed in November 1987 followed by a Determination Order awarding 5 percent for claimant's right leg (knee). Neither party appealed the Determination Order.

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 claimant's physician due to the degenerative arthritis. When the employer did not accept the surgery, claimant filed a request for hearing.

After a hearing, the administrative law judge (ALJ) set aside the employer's denial, finding that claimant's accepted left foot injury in 1986 was the major contributing cause of her need for right knee surgery, and that, therefore, the right knee condition was a compensable consequence of the 1986 injury.

In a February 2, 1996 Order on Review, we reversed the ALJ's order, finding that the medical evidence did not establish that the 1986 left foot condition was the major contributing cause of claimant's need for right knee surgery. *Barbara J. Lloyd*, 48 Van Natta 219 (1996). In that order, we found, based on our interpretation of the 1995 amendments to ORS 656.262(10), that the employer was not precluded from denying claimant's right knee condition even though it had failed to appeal a Determination Order awarding permanent disability benefits based partly on a right knee degenerative condition. *Id.*

Claimant sought judicial review, and the court reversed and remanded relying on its opinion in *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, *rev den* 324 Or 305 (1996) (Messmer II).[1] *Lloyd v. Kmart Corp.*, 146 Or App 384 (1997).

On remand, we relied on the court's decision in *Messmer II* to find that the employer was precluded from denying claimant's right knee condition. *Barbara J. Lloyd*, 49 Van Natta 649 (1997). The employer sought judicial review, and the court remanded for reconsideration based on retroactive amendments to ORS 656.262(10), which the 1997 legislature had enacted.

As the court noted, subsequent to the date of our prior orders, the 1997 Legislature again amended ORS 656.262(10).[2] In *Keith Topits*, 49 Van Natta 1538 (1997), we held that the 1997 amendments to ORS 656.262(10) legislatively overruled the *Messmer* decisions. In *Topits*, we concluded, based on the plain and unambiguous language of the statute, that a carrier's failure to appeal a permanent disability award does not preclude the carrier from denying a previously rated degenerative condition.

Here, as in *Topits*, the carrier is not precluded from denying claimant's current condition (including the degenerative right knee condition) under the amended statute (even if claimant's prior permanent disability award was based in part on that condition and the carrier failed to appeal the award). *See Judy A. Tucker*, 50 Van Natta 1062 (1998); *Patricia A. Landers*, 50 Van Natta 299 (1998); *see also Leslie Mossman, Dcd.*, 49 Van Natta 1602 (amendments to ORS 656.262(10) apply retroactively to cases existing on the effective date of HB 2971). Accordingly, we proceed to the merits.

With regard to the merits of the compensability issue, we republish our reasoning and conclusion as set forth in our February 2, 1996 order which reversed the ALJ's order and reinstated and upheld the employer's denial.

Accordingly, on reconsideration, as supplemented herein, we republish our February 2, 1996 Order on Review in its entirety.

IT IS SO ORDERED.

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[1] In *Messmer II*, the court held that the 1995 amendments to ORS 656.262(10) did not overrule the court's prior decision in *Messmer v. Deluxe Cabinet Works*, 130 Or App 254 (1994) *rev den* 320 or 507 (1995) (*Messmer I*), that an employer's failure to challenge a permanent disability award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that that condition was not part of the compensable claim.

[2] As amended in 1997, ORS 656.262(10) now provides:

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

In the Matter of the Compensation of
PHILLIPPE S. CRATION, Claimant
WCB Case No. 98-01029
ORDER ON REVIEW
Dobbins, McCurdy, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's right knee injury claim. In claimant's brief, he seeks sanctions for the insurer's request for Board review, as well as penalties for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are compensability, sanctions and penalties. We deny the sanction request and affirm.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second paragraph of the "Opinion and Conclusion" on page 2, we change the fifth sentence to refer to Dr. Bald, rather than Dr. Higgins.

Sanctions

On review, claimant contends that he is entitled to sanctions because the insurer's appeal was "initiated without a reasonable prospect of prevailing." (Claimant's br. at 1).

ORS 656.390(1) allows the Board to impose an appropriate sanction against an attorney who files a frivolous request for review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2).

Here, we find that the insurer's challenges to claimant's right knee injury claim involved questions of fact, which are colorable on the record. The insurer's arguments are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. *See Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996); *Gerard R. Schiller*, 48 Van Natta 854 (1996). Under these circumstances, we are not persuaded that the insurer's request for review was frivolous. Accordingly, claimant's request for sanctions is denied.

Penalties

On review, claimant contends that the insurer's appeal constitutes an unreasonable resistance to the payment of compensation and he is entitled to penalties. To begin, with the exception of "sanctions" under ORS 656.390 and "remand" under ORS 656 295(5), our review is limited to the issues raised at hearing when the record was developed. Consequently, we have serious reservations regarding our authority to consider claimant's "penalty" request. In any event, we need not resolve that procedural question because, even if we were authorized to address such an issue, we would decline to assess a penalty.

A penalty is available if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Here, the insurer denied the claim on the basis that there was insufficient evidence or objective findings that claimant suffered an injury on or about September 22, 1997 while in the course and scope of employment. (Ex. 6). Claimant did not report any injuries until October 1, 1997. Although claimant's "827" form indicated he sustained a right knee injury on September 22, 1997 (Ex. 3), the initial medical report did not provide a history of a fall onto his knees. (Ex. 2). Dr. Chaser's October 7, 1997 chart note indicated that claimant fell on both *elbows* in early September 1997. (Ex. 2-1). Dr. Bald

found that claimant was a poor historian and was very vague about the onset of his symptoms. (Ex. 5-6). He said it was unclear in reviewing the records whether claimant had a specific injury at the employer. (*Id.*) Dr. Bald found claimant had generalized systemic complaints of multiple aches and pains that were unrelated to the claim and his work activities. (Ex. 5-8). He felt the possibility of a systemic inflammatory process should be evaluated. (Ex. 5-9).

In light of claimant's delayed reporting of an injury and his failure to report a fall to his knees on October 7, 1997, as well as Dr. Bald's report questioning a specific injury, we conclude that the insurer had a legitimate doubt regarding its liability for claimant's right knee injury. Accordingly, even assuming that we could address the "penalty" issue, we would find that the insurer's denial was reasonably issued and the request for Board review was not unreasonable. Consequently, claimant would not be entitled to an award of penalties.

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 $1,000, payable by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986). Likewise, no fee is awarded for claimant's counsel's unsuccessful efforts regarding the sanctions issue.

ORDER

The ALJ's order dated May 18, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by insurer.

In the Matter of the Compensation of
SHARON A. ELMORE, Claimant
WCB Case No. 97-06268
ORDER ON REMAND
Gatti, Gatti, et al, Claimant Attorneys
James B. Northrop (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' agreement. On August 17, 1998, we approved the parties' Claim Disposition Agreement (CDA), in which claimant fully released her past, present, and future non-medical service rights to workers' compensation benefits (including attorney fees or penalties, except those associated with any act or omission occurring after the Board's receipt of the CDA, and attorney fees allowed by the CDA), related to her January 1997 claim.

In light of our approval of the parties' CDA, which contains the aforementioned provision, we conclude that the attorney fee issue raised in this case has been rendered moot. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MAXZIME HONEA, Claimant
WCB Case No. 97-08974
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its partial denial of claimant's current condition, including low back pain and fibromyalgia conditions. On review, the issue is compensability.

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

We do not adopt the section entitled "Current Condition Denial," beginning on page 6 of the Opinion and Order.

We need not determine whether the insurer's "current condition" denial was procedurally proper, because we find that the parties agreed to litigate the compensability of claimant's current condition, including her low back pain and fibromyalgia conditions). (*See* Tr. 4-5).[1]

The insurer argues that claimant currently has a combined condition, based in part on Dr. Carter's recognition of predisposing psychological factors contributing to claimant's current and ongoing pain problems.

We need not determine whether claimant has a combined condition, as opposed to a consequential condition, because we find that claimant has carried her burden under *either* ORS 656.005(7)(a)(A) or 656.005(7)(a)(B).

On the merits, we agree with the ALJ that Dr. Carter's opinion establishes that claimant's work injury was the major contributing cause of her current problems, whatever the diagnoses. In this regard, we find that Dr. Carter's opinion is based not only on the temporal relationship between the work injury and the ensuing problems, but also on the consistency between those problems and the hard work that claimant continued to perform after her injury (contrary to his recommendation). *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996) (Causation evidence that goes beyond a mere chronological connection is legally sufficient to carry claimant's burden). Moreover, because Dr. Carter expressly considered and weighed noncompensable contributors (*e.g.*, predisposing psychological factors and financial pressures), we conclude that his opinion persuasively supports major causation. Under these circumstances, we agree with the ALJ that the denial 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 $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 8, 1998 is affirmed. For services on review, claimant is awarded an $800 attorney fee, to be paid by the insurer.

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[1] At the beginning of the hearing, the ALJ described the issues to include specific denied conditions, including low back pain and fibromyalgia, and stated that there was also a "full-blow[n] current condition denial." Both attorneys agreed that the issues included a denied "current condition," as well as the specific injuries listed. (Tr. 3-4). *See Laura R. Frank*, 50 Van Natta 767, n. 1 (1998) (Where the parties agree to litigate the merits of the denial at hearing, denial's alleged procedural defect is waived and not addressed on review).

In the Matter of the Compensation of
DOUGLAS W. McLAIN, Claimant
WCB Case No. 98-00567
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Dr. Jamison, treating neurologist, apparently examined claimant twice regarding his bilateral CTS condition, on November 17, 1997, and sometime in December 1997. (Exs. 2, 6-2).

Claimant has the burden of proving by a preponderance of the evidence that his occupational disease is caused in major part by his employment conditions. ORS 656.266; ORS 656.802(2)(a). Only Dr. Jamison, Mr. Gustin, treating physician's assistant, and Dr. Gardener, examining neurologist, provide opinions regarding the cause of claimant's CTS condition. Dr. Gardener's opinion does not support compensability. (Exs. 6, 11). For various reasons, claimant urges that we disregard Dr. Gardener's opinion. However, even disregarding Dr. Gardener's opinion, claimant failed to meet his burden of proof.

In *Gormley v. SAIF*, 52 Or App 1055 (1981), the court found that the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" mitigated against a finding of medical causation in terms of probability. Therefore, the *Gormley* court concluded that, because the claimant could not prove more than just the possibility of a causal connection, she failed to carry her burden of proof.

Here, Dr. Jamison's opinion that he "suspect[s] that [claimant's] work activities are the most reasonable medical etiology for the carpal tunnel syndrome" and the CTS "is likely related to repetitive work activities" are also couched in terms of possibility rather than probability. (Ex. 9). Therefore, Dr. Jamison's opinion does not meet claimant's burden of proof.

Moreover, Mr. Gustin's opinion also fails to meet claimant's burden.[1] Mr. Gustin opined that the types of motion required in claimant's work environment were "definitely a contributing factor." (Ex. 10). However, it is not sufficient to establish that work activities were "a contributing factor," claimant must establish that they were "the *major* contributing cause" or factor. ORS 656.802(2)(a) (emphasis added).

We recognize that the use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. *See McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986); *Austin v. SAIF*, 48 Or App 7 (1980). However, given the problems with the opinions of Mr. Gustin and Dr. Jamison, as discussed above and in the ALJ's opinion, we do not find that those opinions, alone or in combination, satisfy claimant's burden of proof.

Accordingly, we agree with the ALJ that claimant failed to establish a compensable occupational disease claim.

ORDER

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

[1] For the purposes of this analysis, we have assumed, without deciding, that this opinion constitutes medical evidence.

In the Matter of the Compensation of
JOHN W. WANTOWSKI, Claimant
WCB Case Nos. 97-10451, 97-05551, 97-08102 & 97-06580
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Thaddeus J. Hettle, Defense Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) upheld Cigna Property & Casualty's denials of the compensability of and responsibility for his bilateral hearing loss claim; (2) upheld Kemper Insurance Company's compensability and responsibility denial of his claim for the same condition; (3) upheld Self-Insured Management Services' (SIMS) responsibility denial of his claim for the same condition; and (4) upheld the Travelers Property and Casualty's compensability and responsibility denial of his claim for the same condition. On review, the issues are compensability and (potentially) responsibility.

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

The ALJ determined that claimant's bilateral hearing loss condition was not compensable. The ALJ concluded, based on the opinion of Dr. Hodgson, an examining physician, that age-related hearing loss (presbycusis) was the major contributing cause of claimant's hearing loss. On review, claimant argues that presbycusis should not qualify as a "preexisting condition" in determining whether claimant's hearing loss is compensable.

As the ALJ noted, in *Willard A. Hirsch*, 49 Van Natta 1311 (1997), we concluded that it was immaterial whether the claimant's presbycusis was a "preexisting condition" within the meaning of ORS 656.005(24) or whether the claimant's hearing loss was a "combined condition" within the meaning of ORS 656.005(7)(a)(B) or ORS 656.802(2)(b). *See also Henry F. Downs*, 48 Van Natta 2094, *recon* 48 Van Natta 2200 (1996) (a claimant is not permitted to extract a portion of a disease (hearing loss) and claim only that portion which is caused in major part by work exposure). We emphasized that the claimant must prove that work exposure was the major contributing cause of his hearing loss. After considering claimant's contentions on review, we find no reason to depart from our analysis in *Hirsch* and *Downs*.

In this case, we agree with the ALJ's reasoning that Dr. Hodgson's opinion establishes that claimant's hearing loss was caused in major part by age-related presbycusis, not work-related noise exposure. Therefore, we find that the ALJ properly upheld the carriers' denials.

ORDER

The ALJ's order dated April 7, 1998, as reconsidered on June 3, 1998, is affirmed.

In the Matter of the Compensation of
MELBA J. CULVER, Claimant
WCB Case No. 98-03224
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that dismissed her hearing request. On review, the issue is the propriety of the ALJ's dismissal of claimant's hearing request.

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

The ALJ dismissed claimant's request for hearing on the ground that she had failed to establish "good cause" for failing to file a request for hearing within 60 days of the insurer's denial. On review, claimant asserts that she has established good cause under *Ogden Aviation v. Lay*, 142 Or App 469 (1996). We disagree.

Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect." *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986); *see also Brown v. EBI Companies*, 289 Or 455 (1980). While the neglect of an attorney's employee who is not responsible for handling hearing requests may be excusable neglect, *see Brown*, 289 Or at 460, neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. *See Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977); *EBI Companies v. Lorence*, 72 Or App 75, 78 (1985).

Unlike *Ogden*, where good cause had been established by the claimant because the failure to timely file the hearing request was attributable to a legal secretary not regularly charged with filing hearing requests, in this case, there is no evidence as to whose neglect in claimant's attorney's office caused the untimely filing. Therefore, we cannot determine if the untimely request was caused by the excusable neglect of an employee not responsible for handling hearing requests or the inexcusable neglect of the attorney or an attorney's employee who is responsible for filing hearing requests. Accordingly, we find that *Ogden* is distinguishable and conclude that claimant failed to establish good cause. Therefore, we affirm.

ORDER

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

In the Matter of the Compensation of
GUSTAVO B. BARAJAS, Claimant
WCB Case Nos. 98-03824 & 98-03276
ORDER DENYING MOTION TO DISMISS
Michael B. Dye, Claimant Attorney
Bostwick, et al, Defense Attorneys

Claimant has requested Board review of Administrative Law Judge (ALJ) Spangler's order that found that claimant was not entitled to interim compensation. Contending that claimant neglected to timely serve notice of her appeal on its attorney, the self-insured employer has moved the Board for an order dismissing claimant's request for review. We deny the motion.

FINDINGS OF FACT

On August 24, 1998, the ALJ issued his order. The order recited that copies had been mailed to claimant, her attorney, the employer, its claim administrator, and its attorney.

On September 10, 1998, the Board received claimant's September 8, 1998 request for review of the ALJ's order. The request included a certificate of service attesting that claimant's attorney had served the following with copies of the request for review: the Board, claimant, the claims administrator, and the employer.

On September 11, 1998, the Board mailed a computer-generated letter to the parties and their attorneys acknowledging receipt of claimant's request for review. The employer's attorney received this acknowledgment on September 14, 1998.

CONCLUSION OF LAW

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656. 295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

The failure to timely file and serve all parties with a request for Board review requires dismissal. *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." *Robert Casperson*, 38 Van Natta 420, 421 (1986).

Here, the 30th day after the ALJ's August 24, 1998 order was September 23, 1998. On September 10, 1998, the Board received claimant's request for review. Because this date is within 30 days of the ALJ's order, we conclude that the request was timely filed. ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(a).

Moreover, even though claimant's attorney did not provide a copy of the request for review to the employer's attorney, because she timely served all "parties," we find no basis to dismiss the request for review.[1] Alternatively, because the employer's attorney received the Board's September 10, 1998 acknowledgment of claimant's request for review on September 14, 1998, and that date precedes the 30-day limit of September 23, 1998, we find that the employer's attorney received timely actual notice of the request for review.

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[1] Contending that claimant failed to comply with OAR 438-011-0005(2), (which provides that copies of a request for review *shall* be mailed to all parties who appeared at the hearing *and to their attorneys*), the employer seeks dismissal of claimant's appeal. Notwithstanding claimant's noncompliance with this informational request, this apparent rule violation cannot result in the loss of our jurisdiction. *See Kimberly L. Murphy*, 41 Van Natta 847, 848 (1989).

Accordingly, we deny the motion to dismiss. The briefing schedule shall be revised as follows. Claimant's appellant's brief must be filed within 21 days from the date of this order. The employer's respondent's brief must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply brief must be filed within 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAN BELLON, Claimant
WCB Case No. 95-13453
ORDER ON REMAND
Ransom, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Liberty Northwest Insurance Corporation v. Bellon*, 155 Or App 269 (1998). The court has reversed our prior order, *Dan Bellon*, 48 Van Natta 1829 (1996), that affirmed an Administrative Law Judge's (ALJ's) order that: (1) directed the insurer to reinstate claimant's temporary total disability (TTD); and (2) assessed a penalty for the insurer's unreasonable termination of TTD. In reaching our conclusion, we relied on *Marie E. Kendall*, 46 Van Natta 2520 (1994), *on recon* 47 Van Natta 335 (1995), which had held that in order for a modified job offer to comply with *former* OAR 436-60-030(5)(c), the employer's notification to the claimant must provide the duration of the job or, if the duration is not known, information of that fact. Citing *Liberty Northwest Ins. Corp. v. Jensen*, 150 Or App 548 (1997) (which reversed a Board order that had applied the *Kendall* rationale), the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In extending a written, physician-approved, modified job offer to claimant, the employer notified him of the beginning time, date, and place, as well as a description of the job and his wages. The employer further advised claimant that "[t]he continued availability of this position will be re-evaluated periodically."

When claimant did not accept the offer and begin the modified employment, the insurer terminated his TTD benefits. Thereafter, claimant requested a hearing, contending that the insurer's termination of benefits was improper because the employer had not fully complied with *former* OAR 436-60-030(5) in that the offer had not stated the "duration of the job."[1]

The ALJ agreed with claimant's contention. Consequently, the insurer was directed to reinstate claimant's TTD benefits and was assessed a penalty for its unreasonable termination. On Board review, we affirmed, relying on the reasoning expressed in *Marie E. Kendall*.

As previously noted, the court has reversed our decision. Citing *Liberty Northwest Ins. Corp. v. Jensen*, 150 Or App at 548, the court has remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

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[1] The ALJ's order refers to subsection (12) of the rule, which is a former version which had been renumbered to subsection (5) on August 18, 1995. Because all relevant events regarding the processing of this claim occurred after August 18, 1995, subsection (5) is the applicable version of the rule.

In *Jensen*, the court reversed a Board order that had reinstated a claimant's TTD benefits because an employer's modified job offer had not stated the "duration of the job." The employer's offer had explained that the position was temporary and would be periodically re-evaluated. Noting that *former* OAR 436-60-030(12)(c) requires the inclusion of the "duration of the job, *if known*," the *Jensen* court reasoned that the rule does not require a statement if the duration is not known. Because there was no allegation that the employer had known the duration of the job and withheld it, the *Jensen* court determined that the job offer was not defective and that the employer had complied with the rule.

Here, in submitting the modified job offer, the employer advised claimant that the "continued availability of this position will be re-evaluated periodically." Moreover, there is no contention that the employer actually knew the job's duration and withheld it from claimant.

In light of such circumstances, consistent with the *Jensen* holding, we find that the employer complied with *former* OAR 436-60-030(5) in extending its modified job offer to claimant. Inasmuch as claimant did not accept the offer and begin the modified employment, we conclude that the insurer's termination of TTD benefits was justified. Consequently, claimant is neither entitled to the reinstatement of his TTD, an "out-of-compensation" attorney fee, nor to a penalty award for the insurer's claim processing action.

Accordingly, on reconsideration of our September 19, 1996 order, the ALJ's order dated April 1, 1996 is reversed.

IT IS SO ORDERED.

October 12, 1998 Cite as 50 Van Natta 2031 (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 OF ABATEMENT
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

On September 23, 1998, we issued an Order on Remand that set aside Douglas County Forest Products/Liberty Northwest's (DCFP/Liberty Northwest's) denial of claimant's occupational disease claim for bilateral hearing loss. Claimant requests reconsideration, contending that he is entitled to a penalty for unreasonable resistance to compensation, as well as an assessed attorney fee at the hearings level and on Board review.

Claimant requests that we consider his previous argument that he is entitled to a penalty for unreasonable resistance to compensation, particularly by Murphy Plywood/Liberty Northwest. In addition, claimant contends that he is entitled to an assessed attorney fee for services at hearing and on Board review. He asserts that the Court of Appeals awarded $5,180 for legal services only at the judicial review level. Claimant requests an assessed attorney fee of $4,500 for services at the hearing level and $3,000 on Board review.

In order to further consider claimant's request, we withdraw our prior order. The carriers are granted an opportunity to respond. To be considered, each carrier's response must be filed within 14 days from the date of this order. Claimant's replies, if any, must be filed within 14 days from the date of mailing of each carrier's response. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSHUA GILLAM, Claimant
WCB Case No. C8-02059
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Zimmerman, et al, Claimant Attorneys

Reviewed by Board Members Bock and Haynes.

On September 11, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for 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, number 16, 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. Because the 30-day "cooling-off" period has now expired, we have reviewed the parties' agreement.

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
ARLINE SMITH, Claimant
WCB Case No. C8-02180
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On September 28, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

The first page of the proposed disposition agreement provides that the total due claimant is $1,260.93 and the total due claimant's attorney is ***$420.32***, for a total consideration of $1,681.25. However, page 3 provides that claimant's attorney will receive an attorney fee in the amount of ***$430.32***.

Absent extraordinary circumstances, attorney fees in claim disposition agreements are limited to 25 percent of the first $12,500, plus 10 percent of any amount in excess of $12,500. OAR 438-015-0052(1). Because the amount given for the attorney fee on the first page of the agreement ($420.32) is consistent with OAR 438-015-0052(1), and because no extraordinary circumstances have been provided for a fee in excess of that allowed by the rule, we conclude that the reference in the body of the CDA to a "$430.32" attorney fee is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $1,681.25, minus a $420.32 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 $420.32, 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
LINDA L. ADAMS, Claimant
WCB Case No. 97-07340
ORDER ON REVIEW
Nancy F.A Chapman, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that upheld the self-insured employer's denial of claimant's aggravation claim for a bilateral hearing loss condition. On review, the issues are *res judicata* and aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings".

CONCLUSIONS OF LAW AND OPINION

This matter is before us pursuant to the employer's denial of claimant's aggravation claim for a March 1997 worsening of her bilateral sensorineural hearing loss. To establish a compensable aggravation, claimant must prove that she has sustained an actual worsening resulting from her compensable February 1992 injury. ORS 656.273(1). On review, the parties agree that claimant has sustained an actual worsening, and that her increased hearing loss is attributable to an autoimmune disorder of the inner ear. The dispositive issue is whether this autoimmune disorder is compensably related to the accepted injury.

Specifically, the employer contends that claimant's autoimmune disorder is the result of hereditary or idiopathic factors rather than claimant's compensable work injury. Claimant argues that the employer is precluded from denying the compensability of claimant's autoimmune disorder under the doctrine of *res judicata*. In the alternative, claimant contends that the employer's denial is not supported by the medical record. We agree with claimant that the denial is barred.

Under the *res judicata* doctrine of "issue preclusion", a party cannot relitigate an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. *Drews v. EBI Companies*, 310 Or 134, 139 (1990). Thus, a carrier cannot avoid the preclusive effect of a prior determination that a condition is compensable by presenting new evidence regarding diagnosis and etiology of that condition. *See Katherine A. Wood*, 48 Van Natta 2196 (1996); *David R. Sills*, 48 Van Natta 1621 (1996).

Here, claimant relies on the preclusive effect of the Board's January 18, 1996 Order on Review, which was not appealed and became final as a matter of law. (Ex. 120) In that order, the Board affirmed an ALJ's decision to set aside the employer's denial of an aggravation claim for a prior worsening of claimant's bilateral sensorineural hearing loss in March 1994. In reaching its decision, the Board rejected Dr. Hertler's opinion that claimant's increased hearing loss in March 1994 was the result of an inherited sensorineural hearing loss rather than the compensable injury. (Ex. 83). Instead, the Board deferred to Dr. Epley's opinion that the further hearing loss was attributable to inner ear trauma caused by the compensable injury which triggered a progressive autoimmune response. (Exs. 78, 78a, 79b, 84 and 85A-56/57/58/72/73). Based on Dr. Epley's opinion, the Board concluded that the increased hearing loss in March 1994 was caused by a compensable condition, and that determination was essential to the Board's final decision to set aside the employer's aggravation denial. Thus, the Board's January 18, 1996 order creates a *res judicata* bar to any subsequent denial of the condition causing the increased hearing loss in March 1994.

It, therefore, follows that the aggravation denial presently before us is barred if the condition causing the increased hearing loss in March 1997 is the same condition the Board found compensable in its January 18, 1996 order. Drs. Epley, Brown and Hodgson have opined that the autoimmune inner ear disease responsible for the March 1997 worsening also caused the increased hearing loss in March 1994, and there is no contrary medical opinion. (Exs. 141-2, 160-3 and 161-7/8/11). Accordingly, the employer is precluded from arguing that the March 1997 worsening is attributable to a noncompensable autoimmune disorder, and it's aggravation denial must be set aside.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's brief on review), the complexity of this issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

ORDER

The ALJ's order dated March 19, 1998 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's August 28, 1997 aggravation denial is reversed. The employer's denial is set aside, and the claim is remanded to the employer for further processing in accordance with law. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded a $5,000 attorney fee for services at hearing and on Board review, to be paid by the employer.

October 15, 1998 Cite as 50 Van Natta 2035 (1998)

In the Matter of the Compensation of
MARK S. COYL, Claimant
WCB Case No. C8-02237
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 5, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first page of the proposed disposition agreement provides that the total due claimant is $19,875 and the total due claimant's attorney is $4,125, for a total consideration of $24,000. On page 3, line 3, the agreement originally provided that the total consideration was $20,000. However, by handwritten interlineation, claimant's attorney revised the agreement to provide for a total consideration of $24,000, consistent with page one of the document. The change was initialed only by claimant's counsel.

Because the SAIF Corporation's adjuster and trial counsel signed and dated the agreement after claimant's attorney revised and signed it, we find that SAIF approved the interlineation revision on page 3, (which is consistent with page 1 of the agreement). Accordingly, we interpret the agreement as providing for a total consideration of $24,000, with $19,875 payable to claimant and $4,125 as an attorney fee.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $4,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES A. CRUISE, JR., Claimant
WCB Case No. TP-98007
THIRD PARTY DISTRIBUTION ORDER
Black, Chapman, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds of a third-party settlement. *See* ORS 656.593(3). Specifically, the dispute concerns whether the paying agency (Scott Wetzel Services, hereafter Wetzel) can include in its third party lien costs attributable to two insurer-arranged medical examinations (IMEs), and the cost of two future flare-ups as reasonably to be expected future claim costs.[1] We conclude that these costs are not reimbursable and that a distribution in which Wetzel receives $10,088.88 is "just and proper."

FINDINGS OF FACT

Claimant compensably injured his neck on March 6, 1997 when his truck was struck from behind by another semi-truck. The claim was accepted as a lumbosacral strain. Claimant was treated by Dr. Hagie, D.O., who diagnosed "sacroiliac joint and ligament strain" and a possibility of a herniated nucleus pulposus at L5-S1. After an MRI showed no disc herniations, Dr. Hagie's impression was sacroiliac ligament strain with joint inflammation. Dr. Hagie referred claimant to Dr. Thomashefsky, an orthopedist, in May 1997.

Dr. Thomashefsky diagnosed sacral sprain/strain syndrome, mostly left and possible lumbar radiculopathy. Dr. Thomashefsky opined that claimant was "permanent and stationary" although claimant was continuing to receive joint manipulation and rehabilitation. Dr. Thomashefsky also proposed treating claimant with a dextrose-based proliferant to strengthen claimant's ligaments. The doctor indicated that medical studies suggested that proliferant treatment was effective in causing the ligaments to heal further.

Claimant began receiving the proliferant injections and continued exercise and massage treatments.

On July 7, 1997, claimant attended an examination arranged by the insurer with Drs. Yerby and Schilperoort. These physicians diagnosed lumbosacral strain by history and instability of the right sacroiliac joint. The physicians opined that claimant was medically stationary with regard to the March 6, 1997 injury.

In an August 25, 1997 letter, Dr. Thomashefsky disagreed with Drs. Yerby and Schilperoort's opinion that claimant was medically stationary. Dr. Thomashefsky believed that claimant could get back to "100% normal" if the proliferant shots were continued 2-3 more times. Dr. Hagie also disagreed with the report of Drs. Yerby and Schilperoort and felt that claimant was improving with the proliferant therapy.

On September 22, 1997, Dr. Thomashefsky indicated that claimant was "maximally medically improved," and gave claimant a release to return to work full time. Dr. Thomashefsky stated that no other examinations, consultations or imaging studies needed to be done.

In late December 1997, prior to claim closure, claimant returned to Dr. Thomashefsky with a flare-up of his injury. Physical therapy and joint manipulation were not helpful and Dr. Thomashefsky gave claimant a proliferant injection on January 15, 1998.

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[1] Although claimant originally petitioned the Board for approval of the settlement under ORS 656.587, Wetzel no longer contests the reasonableness of the settlement and argues only that its lien should include the cost of IMEs and future claim costs associated with flare-ups. Accordingly, we conclude that the propriety of the third party compromise is no longer disputed.

On March 25, 1998, claimant attended a second IME with Drs. Schilperoort and Howieson. These physicians diagnosed a low back strain which had resolved and a past history of sacroiliac joint instability which was not evident on the date of the examination. They opined that claimant was medically stationary and should have been regarded as medically stationary three months post injury. Dr. Thomashefsky agreed with Drs. Schilperoort and Howieson that claimant was medically stationary although he did not agree with other portions of the report.

The claim was closed by a Determination Order dated May 20, 1998 which awarded temporary, but no permanent, disability.

Claimant pursued a civil cause of action against the third party. This action was settled for $28,810.

Wetzel has paid a total of $11,786.88 on the claim. This figure includes $8,536.69 in medical benefits, including two IMEs which cost $849 each. In addition, Wetzel paid temporary disability benefits totaling $3,250.19. Wetzel also asserts an entitlement to future claims costs. Wetzel believes that the balance of the third party settlement proceeds after deduction of the attorney fee and claimant's statutory share will be approximately $14,604.45. It asserts an entitlement for the entire balance of the proceeds in order to recover its lien, including future projected claims costs.

CONCLUSIONS OF LAW AND OPINION

Wetzel argues that it should be able to include the costs of two IMEs in its lien and should also be allowed to recover the costs of two future flare-ups as future anticipated claims costs. Claimant argues that the IME costs may not be included in the carrier's lien. In addition, claimant argues that the future medical expenses have not been proven to a reasonable degree of certainty. For the following reasons, we agree with claimant that the costs may not be included in Wetzel's lien.

If the worker settles a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); *Estate of Troy Vance v. Williams*, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

In determining a "just and proper" distribution, we judge each case based on its own merits. *Urness v. Liberty Northwest*, 130 Or App 454 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. *Id.* Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination was based on the merits of the case. *Id.*

It is well-settled that claim evaluation reports are analogous to litigation reports and, as such are not justly and properly includable in a paying agency's lien against a third party recovery. *Jack S. Vogel*, 47 Van Natta 406 (1995); *David G. Payne*, 43 Van Natta 918 (1991). Wetzel argues that the IMEs were necessitated by Dr. Thomashefsky's contradictory statements regarding whether claimant was medically stationary and seeks to distinguish *Vogel* and *Payne* on the basis that the exams were required because of Dr. Thomashefsky's conduct.

Wetzel argues that the first IME was necessitated because Dr. Thomashefsky's opinion was unclear regarding claimant's medically stationary status. The problem with this argument is that there is no evidence in this record that Wetzel sought clarification from Dr. Thomashefsky of claimant's medically stationary status or requested a closing exam prior to the first IME. In addition, the record establishes that both the attending physician (Dr. Thomashefsky) and Dr. Hagie indicated after the first IME that claimant was *not* medically stationary. Presumably, these physicians would have given the same response had Wetzel requested an opinion prior to pursuing the IME and no examination would have been necessitated at that time.

With regard to the second IME, if the record established that the attending physician believed that claimant was medically stationary, but was reluctant to perform a closing examination, we might have agreed with Wetzel's argument that the second IME should be reimbursed. *See Jack S. Vogel*, 47

Van Natta at 409. However, the record does not establish that a closing evaluation was requested from claimant's attending physician prior to the second IME. Under these circumstances, we find that the IMEs were for claim evaluation purposes and, consistent with the rationale of the cases cited above, we do not consider it "just and proper" for Wetzel to receive reimbursement for its claim costs attributable to the IME reports.

We now turn to the question of whether the costs of future flare-ups claimed by Wetzel can be recovered from the settlement. To support a lien for anticipated future medical expenses, the paying agency must establish that it is reasonably certain to incur such expenditures. *Sharon K. Falsetto*, 49 Van Natta 1202, *on recon* 49 Van Natta 1573 (1997).

In *Mona R. Skelton*, 47 Van Natta 882 (1995), we held that the paying agency was not entitled to recover its projected lien for anticipated future expenditures because the evidence established that future medical treatments were only a "possibility" rather than a reasonable certainty, especially in light of the claimant's treating doctor's report that no further treatment was necessary for the claimant's elbow injury. Similarly, in *Sharon K. Falsetto*, we found that it was not reasonably to be expected that the insurer would incur future expenses for fusion surgery because the surgery was only a "possibility."

Here, there is no medical evidence indicating that future flare-ups are reasonably to be expected or reasonably certain. The only evidence supporting Wetzel's contention that it should be able to include the cost of flare-ups in its lien for future expenditures is an affidavit from its regional claims manager, Mr. Stromberg. Mr. Stromberg's affidavit states that the indemnity and time loss costs associated with claimant's December 1997 flare up total $1,481.17. Based upon this figure, Mr. Stromberg states that he believes reserves suitable to cover at least two future flare-ups such as the flare-up claimant experienced in December 1997 is a "minimum prudent sum."

In the absence of any medical evidence that future flare-ups of claimant's condition are reasonably to be expected (as well as an estimation regarding the present value of these alleged projected medical expenses), we find that future flare-ups are only a possibility. Under such circumstances, Wetzel is not entitled to recover its projected lien for future anticipated claims expenses.

In conclusion, we hold that it is "just and proper" for Wetzel to receive reimbursement for its actual claim costs, *i.e.*, $10,088.88. *See* ORS 656.593(3). However, for the reasons expressed above, we hold that Wetzel is not entitled to recover the cost of the two IMEs ($1,698) or the cost of future possible flare-ups. Claimant (or his counsel) is directed to forward the aforementioned sum ($10,088.88) to Wetzel in reimbursement of its "just and proper" share of claimant's third party settlement.

IT IS SO ORDERED.

October 12, 1998 Cite as 50 Van Natta 2038 (1998)

In the Matter of the Compensation of
ROBERT NICKLE, Claimant
Own Motion No. 97-0380M
OWN MOTION ORDER OF ABATEMENT
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 22, 1998 Own Motion Order, in which we affirmed the SAIF Corporation's July 15, 1998 Notice of Closure in its entirety.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS G. FRYE, Claimant
Own Motion No. 98-0172M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's July 2, 1998 Notice of Closure, as amended on July 29, 1998, which closed his claim with an award of temporary disability compensation from April 9, 1998 through April 29, 1998. The employer declared claimant medically stationary as of June 23, 1998.

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. The employer submitted its response on August 19, 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 a carrier'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, claimant states that "I tried to do what the Drs. said for years [until] I had to have the surgery, I find out then is no [disability] for my [condition] because of a time line. I believe this is wrong. And had never been aware of this. *** I understand that there is a [retro account] that should fit my time line for disability [due] to my persistent disability. *** Please [check my] claim and give me what is due for compensation."

We assume that claimant is not contesting his medically stationary date nor the amount of temporary disability he was awarded.[1] Rather, we interpret claimant's request as his asking us to grant other workers' compensation benefits. We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990).

Accordingly, we affirm the employer's July 2, 1998 Notice of Closure, as amended on July 29, 1998, in its entirety.

IT IS SO ORDERED.

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[1] In a June 23, 1998 doctor's report, Dr. Schroeder, claimant's attending physician, noted that "[claimant's] condition is now medically stationary and I recommend claim closure." Dr. Schroeder had also previously released claimant to return to "full work" on April 30. These opinions are unrebutted. Thus, even if claimant were contesting his medically stationary date, 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 or that he was entitled to additional temporary disability beyond April 29, 1998. We therefore conclude that the employer's closure was proper.

In the Matter of the Compensation of
GENE H. GOSDA, Claimant
WCB Case No. 96-03915
ORDER ON REMAND
Aller & Morrison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998). The court has reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order upholding the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. Relying on *Manual Garibay*, 48 Van Natta 1476 (1996), the ALJ had determined that, because claimant had not invoked the last injurious exposure rule (LIER) as a rule of proof, he could not rely on the rule to establish the compensability of his claim. Reasoning that the LIER rule of proof is applicable in any case in which the evidence supports its application, the court has concluded that we should have applied it to establish the compensability of claimant's occupational disease claim. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant began working as a truck driver in about 1975. He first experienced hand numbness after he began working for the insured in June 1992.

Claimant first sought treatment for hand symptoms on January 26, 1996. On January 29, 1996, claimant filed a claim for bilateral carpal tunnel syndrome (CTS). On April 11, 1996, the insurer denied claimant's claim. Claimant requested a hearing.

Based on the persuasive medical evidence, the ALJ determined that claimant's work as a truck driver caused his CTS. Relying on *Manual Garibay*, 48 Van Natta 1476 (1996), however, the ALJ reasoned that, because claimant had not invoked the last injurious exposure rule (LIER) as a rule of proof, he could not rely on the rule (or his long history of truck driving before his exposure with the insured) to establish the compensability of his claim. Thus, because claimant did not prove causation with respect to *this* employer, the ALJ concluded that the claim failed.

On review, the Board adopted and affirmed the ALJ's order. Claimant petitioned the court for judicial review of our order.

The Court of Appeals reversed our order, reasoning that the LIER of proof is applicable in any case in which the evidence supports its application. *Gosda*, 155 Or App at 120. The court concluded that we should have applied the LIER of proof in this case to establish the compensability of claimant's condition, because the medical evidence indicates that claimant's work exposure (as a whole) caused his CTS. Consequently, the court remanded the case for reconsideration.

On reconsideration, we agree with the ALJ that claimant's truck driving caused his bilateral CTS. Accordingly, we adopt the ALJ's reasoning and conclusion in this regard, through the fifth full paragraph on page 4 of the Opinion and Order. (*See* Exs. 10, 12).

Under the LIER of proof, the claim is compensable because the medical evidence establishes that claimant's work activities caused his condition. *Gosda*, 155 Or App at 125; *see Runft v. SAIF*, 303 Or 493, 499 (1997) (As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure the disease-causing conditions at a particular employment actually caused the disease and the claimant need only prove that the disease was caused by employment-related exposure).

We further find no evidence that it was impossible for claimant's work for the insured to have caused his CTS condition or that a prior employment was the sole cause of that condition. Consequently, assuming for the sake of argument that the insurer could attempt to shift responsibility under LIER as a "rule of assignment," the insurer may not avoid responsibility for claimant's bilateral CTS. *See Willamette Industries v. Titus*, 151 Or App 76, 80 (1997); *Michael L. McKinney*, 50 Van Natta 1595 (1998); *Richard A. Young*, 50 Van Natta 871 (1998).

Accordingly, on reconsideration, the ALJ's order dated August 9, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
AUDREY KEELAND, Claimant
WCB Case No. 97-08886
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of claimant's aggravation claim for a right knee condition; and (2) set aside its denial of her occupational disease claim for osteoarthritis of the right knee. On review, the issues are compensability and aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right knee in July 1995. The insurer accepted a disabling right knee medial meniscus tear. (Ex. 15). A Notice of Closure dated December 4, 1995 awarded claimant 15 percent scheduled permanent disability for loss of use or function of her right leg. (Ex. 20).

On June 2, 1997, she sought treatment from Dr. Teal for right knee pain. (Ex. 22). He diagnosed increasing osteoarthritis of the right knee with a possible lateral meniscal degenerative tear. (*Id.*) On the same date, Dr. Teal signed a "Notice of Claim for Aggravation of Occupational Injury or Disease." (Ex. 23).

The insurer denied claimant's aggravation claim on October 27, 1997 on the basis that her condition had not worsened since the last award or arrangement of compensation. (Ex. 34). At hearing, in response to the insurer's motion for "summary judgment," claimant made an occupational disease claim for osteoarthritis of the right knee. (Tr. 12). The insurer amended its denial to deny the occupational disease claim and chose to litigate the merits of that claim at that time. (Tr. 12, 13).

The ALJ found there was no evidence of a "combined" condition and, therefore, claimant must only prove that the accepted condition was a material cause of the "worsening." The ALJ relied on Dr. Teal's opinion that the work injury caused a progression in the arthritic condition and, therefore, set aside the insurer's aggravation denial. The ALJ also found that claimant's work activities were the major contributing cause of her right knee arthritis and the ALJ set aside the insurer's denial of her occupational disease claim.

On review, the insurer argues that there is no persuasive medical evidence that claimant's compensable medial meniscus condition has worsened since claim closure and, therefore, claimant has failed to establish a compensable aggravation claim.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

We begin our analysis with a determination of whether claimant's current right knee condition is a compensable condition. The insurer accepted a disabling right knee medial meniscus tear. (Ex. 15).

On June 2, 1997, she sought treatment from Dr. Teal for right knee pain. (Ex. 22). He diagnosed increasing osteoarthritis of the right knee, with a possible lateral meniscal degenerative tear. (*Id.*) Dr. Teal had reviewed x-rays and said that the medial degenerative changes had worsened. (Ex. 22-2). A June 3, 1997 MRI showed that the menisci and ligaments appeared intact, although degenerative changes were present, particularly within the lateral meniscus. (Ex. 24). There were arthritic changes involving the medial femoral tibial compartment and the femoral patellar articulation. (*Id.*) Dr. Teal concluded that the MRI showed no major surgical problems. (Ex. 25).

Dr. Mayhall examined claimant on behalf of the insurer. He concluded that the MRI scan indicated claimant's right medial meniscus was intact without further tearing. (Ex. 26-5). He found that her right knee degenerative arthritis had progressed and he felt the arthritis was the major contributing cause of her need for treatment. (*Id.*) Dr. Teal concurred with Dr. Mayhall's report. (Ex. 27).

Based on the reports from Drs. Teal and Mayhall, the diagnosis of claimant's current right knee condition is degenerative arthritis, which is not the same as the accepted right knee medial meniscus tear. The MRI scan and the reports from Dr. Mayhall and Dr. Teal indicate that claimant's right medial meniscus was intact and had not sustained further damage. Because right knee degenerative arthritis is not an accepted condition, claimant must first establish that the arthritis condition is a compensable condition.[1]

Alternatively, claimant asserts that her current right knee arthritis condition constitutes a compensable occupational disease claim. To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of her right knee degenerative arthritis. 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).

The insurer contends that ORS 656.802(2)(b) applies to this case. For the following reasons, we disagree.

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 her right knee arthritis was caused in major part by 24 years of employment activities working as a waitress for the employer. This is an initial occupational disease claim for her arthritis condition. Therefore, the onset of this occupational disease claim is approximately 1971 (Ex. 4), when claimant began working for the employer. *See New Portland Meadows v. Dieringer*, 153 Or App 383 (1998); *Mark H. Davidson*, 49 Van Natta 1918, 1920 (1997). Thus, the question is whether claimant had any right knee arthritis that preexisted the beginning of her employment in 1971.

There is no evidence that claimant had a right knee arthritis before she began working for the employer in 1971. Therefore, we conclude that there is no right knee arthritis condition that preexisted the initial onset of this claim. Because claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition, ORS 656.802(2)(b) does not apply to this case.

To establish compensability under ORS 656.802(2)(a), claimant must prove that her work activities for the employer were the major contributing cause of her right knee arthritis. Claimant relies on Dr. Teal's opinion to establish compensability of the arthritis condition. In evaluating the medical

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[1] We are not persuaded that claimant's current right knee arthritis condition is related to the accepted right knee medial meniscus tear. The MRI scan and the reports from Dr. Mayhall and Dr. Teal indicated that claimant's right medial meniscus was intact and had not sustained further damage. (Exs. 24, 25, 26, 27). Moreover, claimant's current need for treatment is related to her osteoarthritis, not the medial meniscus. (Exs. 22, 26-5, 27). Based on the medical evidence, we agree with the insurer that claimant has failed to prove a worsening of her accepted right knee medial meniscus tear.

evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we are persuaded by Dr. Teal's opinion.

After claimant's July 1995 injury, Dr. Teal performed surgery on her right knee. (Ex. 13). An MRI in August 1995 showed degenerative change in the medial and lateral meniscus. (Ex. 9). After surgery, Dr. Teal commented that the degenerative changes in claimant's knee would prolong her recovery. (Ex. 17). On June 2, 1997, Dr. Teal diagnosed increasing osteoarthritis, right knee, with a possible lateral meniscal degenerative tear. (Ex. 22-2). A June 3, 1997 MRI indicated claimant had degenerative changes, particularly within the lateral meniscus, and arthritic changes involving the medial femoral tibial compartment and the femoral patellar articulation. (Ex. 24). Dr. Teal found no major surgical problems in claimant's knee. (Ex. 25).

On October 27, 1997, Dr. Teal reported:

> "I frankly think since [claimant] has done little else other than worked at [the employer] for the last 20 years on her feet all day long, twisting, turning, kneeling, squatting that I believe it is appropriate in this isolated circumstance to declare that 51%, or at least 51%, is due to her on-the-job activities rather than other coincidental activity." (Ex. 33).

In a deposition, Dr. Teal explained that the fact that claimant was past middle age, was overweight and had a history of being on her feet increased the chance of developing arthritis in the lower extremity. (Ex. 36-9, -10). He adhered to his earlier opinion that claimant's work activities were the major reason for the worsening and development of osteoarthritis. (Ex. 36-13, -17). He explained that her activities of prolonged standing on a hard surface, twisting, turning, kneeling, squatting and climbing contributed to her condition. (Ex. 36-13). His opinion that the work activities were the major cause of claimant's degenerative changes was expressed in terms of certainty, rather than guesswork. (Ex. 36-19).

The insurer contends that Dr. Teal's opinion is not persuasive because he rendered inconsistent opinions. The insurer argues that Dr. Teal reported in October 1997 that claimant's degenerative disease was related to her aging, rather than work exposure. In a chart note dated October 20, 1997, Dr. Teal commented that claimant "still has lateral compartment degenerative changes which will also need treatment which are probably not specifically related overwhelmingly to her on-the-job activities and probably are, at least in a 65 year old lady, co-existent." (Ex. 32-1). In a deposition, however, Dr. Teal explained that he made a "statement there that at the time I think was an error in the first place." (Ex. 36-7). After further reflection, Dr. Teal concluded that claimant's work activities were the major contributing cause of her arthritis condition. (Exs. 33, 36-8, -13).

The insurer also contends that Dr. Teal's opinion is not persuasive because he did not explain his change of opinion. In a concurrence letter from claimant's attorney, Dr. Teal agreed that claimant continued to suffer from the effects of the work injury as well as arthritis. (Ex. 30a-2). He agreed that the work injury had worsened the arthritis. (*Id.*) Considering the work injury and the effect the work injury had on the development of arthritis, Dr. Teal agreed that the work injury was the major contributing cause of the current need for treatment. (*Id.*) *See Sandra L. DeHart*, 49 Van Natta 1437 (1997) (surgeries for the compensable C5-6 condition, together with work activities, were the major contributing cause of the current C6-7 condition). At the deposition, Dr. Teal addressed the causation and development of the arthritis. He testified that claimant's work activities were the major contributing cause of the "worsening and the development of this in the first place." (Ex. 36-13). Although in the earlier report Dr. Teal had focused on the major cause of the current need for treatment, at the deposition he discussed the causation of the entire arthritis condition. Under these circumstances, we are not persuaded that Dr. Teal "changed" his opinion.

The insurer argues that Dr. Teal engaged in "guesswork" to assign at least 51 percent of the cause to claimant's work exposure. At a deposition, the insurer's attorney asked Dr. Teal whether assigning a percentage contribution for causation was "kind of a guesswork thing[.]" (Ex. 36-17). Dr. Teal responded: "No question." (*Id.*) However, Dr. Teal explained:

> "It is like a lot of things in medicine. It is something on one's best guesstimate based on what one looks at. And in this circumstance where I've known the individual for the better of part of 20 years, I think that my opinion is still taken from what I feel are the facts." (Ex. 36-18).

He clarified that his opinion on causation was based on certainty, not just guesswork. (Ex. 36-19).

The only other medical opinion is from Dr. Mayhall, who did not specifically address whether claimant's arthritis was work-related. Dr. Mayhall concluded that claimant's right knee degenerative arthritis was the major contributing cause of her need for treatment. (Ex. 26-5). He indicated that the degenerative change throughout the knee had worsened, which was consistent with osteoarthritis and its "natural progression." (*Id.*) Because Dr. Mayhall did not specifically address the major contributing cause of claimant's arthritis, his opinion is not inconsistent with Dr. Teal's opinion.

Based on Dr. Teal's opinion, we conclude that claimant has established that her employment activities as a waitress for the employer over 24 years were the major contributing cause of her right knee arthritis condition.[2]

Claimant's attorney is entitled to an assessed fee for services on review regarding the occupational disease claim for right knee arthritis. 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 June 11, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside the insurer's aggravation denial is reversed. The insurer's aggravation denial is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

[2] Claimant argues that if we find the arthritis condition compensable, then her current condition must also be considered compensable for purposes of establishing the aggravation claim. We disagree. The insurer accepted a right knee medial meniscus tear. As we discussed earlier, the diagnosis of claimant's current right knee condition is degenerative arthritis. The MRI scan and the reports from Dr. Mayhall and Dr. Teal indicated that claimant's right medial meniscus was intact and had not sustained further damage. (Exs. 24, 25, 26, 27). Moreover, claimant's current need for treatment is related to her osteoarthritis, not the medial meniscus. (Exs. 22, 26-5, 27). Based on the medical evidence, we agree with the insurer that claimant has failed to prove a worsening of her accepted right knee medial meniscus tear.

In the Matter of the Compensation of
JEAN R. LOUIS, Claimant
WCB Case No. 97-07835
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock, Biehl, and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of his injury claim for a right shoulder strain, multiple contusions, lumbosacral strain and hematuria. On review, the issue is whether claimant's injuries arose within the course and scope of his employment. We reverse.

FINDINGS OF FACT

Claimant worked as a pizza dough production worker. On June 17, 1997, claimant was involved in a physical altercation with his supervisor, Mr. Melton. The fight ensued when Mr. Melton asked claimant to wash some trays and claimant, who was working on another task, refused.

Claimant testified that Mr. Melton was the aggressor; that Mr. Melton jumped on claimant and pushed him against a wall and then onto the floor. Mr. Melton testified that, in the course of arguing about claimant's refusal, claimant threw the first punch and hit him in the chin. Two other production

workers, Mr. Raku and Mr. Noel, testified that they witnessed the altercation and that Mr. Melton grabbed claimant, pushed him into the wall and then onto the floor. Mr. Gist, the commissary manager, did not witness the fight, but he believed that claimant was the aggressor.

Claimant sought emergency treatment immediately after the incident. He gave a history of being assaulted at work and pushed against a hard surface. Dr. Chipman diagnosed a contusion/abrasion of the right shoulder. Claimant returned for treatment the next day, June 18, 1997, complaining of pain and blood in his urine. Dr. Dodge diagnosed hematuria, probable urinary tract infection.

Between June 20, 1997 and July 14, 1997, claimant was treated by Dr. Yarusso who diagnosed resolving multiple contusions and a resolved lumbosacral strain related to the assault at work.

On September 15, 1997, claimant was examined by Dr. Neumann at the insurer's request. Dr. Neumann diagnosed multiple contusions and shoulder strain injuries secondary to the June 17, 1997 altercation and a hematuria of undetermined etiology.

On September 17, 1997, the insurer denied claimant's claim for bilateral shoulder strains, lumbosacral strain, multiple contusions and hematuria, asserting that his injuries did not arise out of and in the course of his employment.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded "[t]here is no question that the fight arose out of the performance of the parties' respective job duties." Nevertheless, the ALJ was "unable to determine" on this record, "that claimant was not an aggressor or active participant" in the fight. The ALJ therefore determined that claimant failed to prove that he suffered a compensable injury.

On review, claimant argues that because the altercation arose from a quarrel directly connected to his work duties, his injuries are compensable regardless of whether or not he was an active participant in the assault. Alternatively, claimant argues that a preponderance of the evidence establishes that he was not an active participant. For the reasons set forth below, we find claimant's assault-related injuries compensable.

First, for an injury to be compensable, it must arise out of and in the course of employment. ORS 656.005(7)(a). The phrases "arise out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). Under this "work-connection" test, both elements must be satisfied to some degree. *Id.* In this case, it is undisputed that claimant's injuries occurred "in the course of" his employment, as the incident in question occurred on the employer's premises during regular work hours. The pertinent inquiry here is whether claimant's injuries "arose out of employment" and, if so, whether there is any statutory bar to compensation.

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." *Norpac Foods Inc. v. Gilmore*, 318 Or 363, 366 (1994). In *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), 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 Court held that, in general, the risk of assault by a coemployee in the workplace is a risk to which the work environment exposes the employee. *Id.* at 40. In other words, the test is whether the workplace assault was caused by circumstances associated with the work environment. *Id.*

Here, it is undisputed that claimant was injured in a physical fight with his supervisor. A preponderance of the evidence indicates that this altercation resulted from claimant's refusal to wash the trays upon Mr. Melton's specific request that he do so. Indeed, the record is devoid of evidence of any other motive for the assault or evidence that claimant and his supervisor had any contact or relationship separate and apart from the work place. Therefore, we find that the injuries claimant sustained in the assault arose in the course of his employment.

Having determined that claimant's injuries arose out of his employment, we next address whether the 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[.]"

By its terms, 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." Unless both of those elements are met, the exclusion does not apply. *Redman Indus.*, 326 Or at 38 (emphasis in original).

Because ORS 656.005(7)(b)(A) operates to exclude certain injuries from the definition of "compensable injury," once a claimant has shown that his assault-related injuries arose out of and in the course of employment, the burden shifts to the carrier to prove that the exception applies. *See Donald Converse*, 50 Van Natta 1830 (1998). In other words, the carrier must establish by a preponderance of the evidence that the 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. *Id.; See also 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); *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); *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). In this case, as the ALJ found, there is conflicting evidence on the "active participant" issue. Claimant testified that Mr. Melton jumped on him, pushed him against a wall and then onto the floor. Claimant also testified that he did not fight back. (Tr. 20, 49). Two other witnesses, Mr. Raku and Mr. Noel, similarly testified that Melton was the aggressor; that when claimant refused to go and wash the trays, Melton grabbed him and pushed him against the wall and onto the floor.[1] (Tr. 36, 44). Mr. Raku and Mr. Noel also stated that claimant did not throw any punches in the incident. *Id.* Mr. Melton, on the other hand, testified that when he pointed toward the door and told claimant to go home, claimant hit him on the chin and grabbed his uniform. Mr. Melton also testified that he grabbed claimant and pushed him backwards, causing him to hit the wall. (Tr. 24).

Mr. Gist, the commissary manager, did not witness the altercation, although he spoke to claimant, Melton and the witnesses immediately afterwards. Mr. Gist also testified that he spoke to claimant the next day, when he returned to the work premises with Ms. Asberry and a doctor's authorization. (Tr. 52). Ms. Asberry, an acquaintance of claimant's, testified that she accompanied claimant back to work the day after the incident to help sort out what happened, because claimant's English was so poor. (Tr. 47). She also testified that while she was talking to Mr. Gist, Mr. Melton joined the conversation and was very rude, obnoxious and aggressive toward claimant, causing Mr. Gist to order Mr. Melton to leave the room.[2] (Tr. 48).

At best, the evidence regarding claimant's participation in the assault is in equipoise. The ALJ did not make any demeanor-based credibility determinations and, after our review of the record, we are unable to find any material inconsistencies in the record that cause us to conclude that the testimony of

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[1] Mr. Noel also testified that, even before the assault, Mr. Melton was angry at claimant for having called in sick the day before. (Tr. 44). Mr. Melton denied that he was angry with claimant. (Tr. 24-25).

[2] On this issue, Mr. Gist testified that he did not recall the exchange exactly, but he did admit he told Mr. Melton to go away. (Ex. 53).

claimant, Mr. Noel and Mr. Raku is less credible than the contrary testimony of Mr. Melton. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987) (in exercising *de novo* review, Board may assess credibility based upon its evaluation of the substance of a witness's testimony). Consequently, because the insurer has not proven by a preponderance of evidence that claimant was an active participant in the assault which produced his injuries, the statutory exclusion does not apply. *See Redman Industries v. Lang*, 326 Or at 38 (unless both elements of ORS 656.005(7)(b)(A) are met, the exclusion does not apply).

Alternatively, in light of *Donald Converse*, 50 Van Natta at 1830, we find that, even if the record supported a determination that claimant was an active participant in the assault, the evidence fails to establish the next element, *i.e.*, that the assault was "not connected to the job assignment." In *Converse*, we held that to the extent an assault or combat arises out of a quarrel, The subject matter of which is connected or related to the claimant's job assignment, the claimant's assault-related injuries would fall outside ORS 656.005(7)(b)(A).[3]

Here, as the ALJ found, there is no question that the altercation arose out of claimant's and Melton's respective job duties. Claimant refused to wash trays despite the supervisor's specific request that he do so. Therefore, the assault was directly related to (and thereby "connected to") claimant's job assignment as a pizza dough production worker.

The insurer contends that claimant's assault-related injuries are "akin to intentional injuries" and are not compensable pursuant to ORS 656.156(1). We disagree. ORS 656.156(1) requires a "deliberate intention" on the part of the worker to produce injury or death.[4] The statute does not apply where the claimant's injuries result from negligence, carelessness or recklessness. *See, e.g. Youngren v. Weyerhauser*, 41 Or App 333 (1979) (where the claimant intended only to vent frustration, not injure himself, ORS 656.156(1) was inapplicable).[5] In this case, there is no evidence indicating that claimant's injuries resulted from a conscious volitional act on his part to injure himself. Therefore, ORS 656.156(1) is inapplicable.

In addition to proving that the assault arose out of his employment, claimant must also establish medical causation. In other words, he must also show that his various injuries and diagnosed conditions were caused by the workplace assault. *See* ORS 656.005(7)(a); 656.266. While the medical evidence persuasively establishes that claimant sustained multiple contusions, a lumbosacral strain and bilateral shoulder strains in the assault, the record fails to show that the hematuria is compensably related to the assault. Indeed, Dr. Dodge opined that the hematuria was probably due to a urinary tract infection and Dr. Neumann concluded the exact etiology was undetermined. Consequently, we uphold the insurer's denial only insofar as it denied the compensability of claimant's hematuria condition.

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

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[3] We looked to the plain, unambiguous language of the phrase "not connected to the job assignment" and determined that the statutory exclusion applies only to assaults that are separate from, and not linked or joined with, the claimant's assigned work duties. *Donald Converse*, 50 Van Natta at 1830.

[4] ORS 656.156(1) provides as follows:

"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 ORS 656.001- 656.794."

[5] In *Youngren*, the claimant's co-worker boarded up a work exit, making the claimant's job more difficult, and seemed prepared to use physical violence if claimant tried to remove the barrier. In lieu of striking his co-worker, the frustrated claimant struck a metal drum several times, breaking a bone in his hand. 41 Or App at 336.

ORDER

The ALJ's order dated January 27, 1998 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for bilateral shoulder strains, lumbosacral strain and multiple contusions is reversed. That part of the denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's counsel is awarded $3,000, payable by the insurer.

Member Haynes dissenting.

Because I continue to believe that the legislature did not intend to shift the burden of proof under ORS 656.005(7)(b)(A) once a claimant has established a prima facie case of compensability and disagree with the majority's construction of the statute as well as its determination that claimant's assault was "connected to his job assignment," I respectfully dissent from the majority's holding that the claim is compensable.

First, as set forth in my dissenting opinion in *Donald Converse*, 50 Van Natta 1830 (1998) (Member Haynes, dissenting), 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. Second, as also discussed in detail in my dissenting opinion in *Donald Converse*, I disagree with the majority's interpretation of the "connected to the job assignment" element. In this regard, I continue to find guidance in the court's analysis in *Kessen v. Boise Cascade Corp.*, 71 Or App 545 (1984),[1] and maintain that, unless a worker's job entails assaultive conduct, such as a bouncer or boxer, a workplace assault is not connected to the worker's job assignment.

Furthermore, on the merits of this case, I would find that claimant's injuries are not compensable under ORS 656.005(7)(b)(A). The ALJ, after viewing the witnesses and evaluating the testimony, in effect rejected claimant's position that he was attacked by his supervisor, Mr. Melton. Although, as the majority notes, the ALJ did not make explicit demeanor-based credibility findings, I understand his order as essentially finding more credible the testimony from Mr. Melton and Mr. Gist. Thus, I would defer to such testimony and find that, after claimant refused to follow his supervisor's directions to wash trays and then leave the premises, he hit Mr. Melton, whereupon Mr. Melton grabbed claimant and pushed him away. Based on such evidence, I would find that claimant was an "active participant" in an assault.

As with the claimant in *Kessen*, this claimant was neither a boxing instructor, bouncer, nor any other worker whose employment activities might entail assaultive conduct. To the contrary, claimant was a pizza dough production worker. Consequently, unlike the majority, I would find that claimant's assaultive conduct (which followed his refusal of a supervisor's express directive to wash some trays) was "not connected to his job assignment." In addition, and again consistent with my dissent in *Donald Converse* and the rationale expressed in *Kessen*, I would find that claimant's insubordination and confrontation with his supervisor was a deviation from his customary duties as a pizza dough production worker.

Accordingly, based on my understanding of the statutory scheme and controlling case authority, I would hold that the claim is not compensable under ORS 656.005(7)(b)(A). Because the majority reaches a different conclusion, I respectfully dissent.

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[1] In *Kessen*, the claimant, a truck driver, was injured in an assault by a coworker that was precipitated by the claimant's vocal tirade, threatening gestures and accusations that the coworker was one of the supervisor's favored few. The court found that the claimant was an active participant in the assault even though he was the recipient of the only blow struck. The court also concluded that the claimant's confrontation with his coworker was not connected to his job assignment as a truck driver and amounted to a deviation from his customary duties. The court explained: "Unlike a boxing instructor or bouncer, whose job may entail assaultive conduct, claimant's job was to drive truck . . ." 71 Or App at 548.

In the Matter of the Compensation of
VICTOR SCHUNK, Claimant
Own Motion No. 98-0383M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney

The insurer has submitted claimant's request for temporary disability compensation for his compensable L5-S1 disc bulge. Claimant's aggravation rights expired on March 28, 1993.

The insurer submitted its Own Motion Recommendation form which responds affirmatively to all the criteria that claimant must meet in order to qualify for temporary disability benefits. However, the insurer opposes the reopening of the claim on the grounds that "we do not believe that the worker's condition has worsened."[1] Furthermore, the insurer asserts that claimant's epidural injections qualify as a "surgical procedure."

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

Here, the insurer contends that claimant has undergone a surgical procedure in the form of epidural injections. We disagree. We have previously interpreted "surgery" to be an invasive procedure undertaken for a curative purpose which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990). Claimant had two epidural steroid injections. However, there is no persuasive evidence in the record that the epidural steroid injections, in and of themselves, were taken for a curative purpose or, even if they were, resulted in or were likely to result in temporary disability. Accordingly, these injections do not qualify as "surgeries" within the meaning of ORS 656.278(1)(a). Moreover, because the injections were done on an outpatient basis and did not require an overnight stay in a hospital, we do not regard the procedure as "hospitalization" sufficient to justify claim reopening. *Id.*

Accordingly, the record fails to demonstrate that claimant has required or currently 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. Accordingly, we deny the request for own motion relief. 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 insurer's recommendation that we deny reopening of the claim because his condition had not "worsened" is not well founded. Under ORS 656.273(1)(b), a worsening is not established by "[i]npatient treatment of the worker at a hospital for the worker's condition from the original injury." However, ORS 656.273(1)(a) is not applicable because claimant's 1987 claim is in the exclusive jurisdiction of our own motion authority under ORS 656.278. Pursuant to ORS 656.278(1)(a), we may reopen a claim for additional temporary disability compensation under our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Thus, pursuant to ORS 656.278(1)(a), a "worsening" of an own motion claim is defined as requiring inpatient or outpatient surgery or other treatment requiring hospitalization. *Tamera Frolander*, 45 Van Natta 968 (1993).

In the Matter of the Compensation of
THOMAS H. TENPAS, Claimant
Own Motion No. 98-0330M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On September 9, 1998, we abated our August 28, 1998 Own Motion Order in which we declined to reopen his 1986 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. We took this action to consider claimant's motion for reconsideration. With his request, claimant submitted additional information regarding the "work force" issue. Having received the SAIF Corporation's response, we proceed with our reconsideration. On reconsideration, we withdraw our prior order and issue the following order.

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

It is 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 is not in the work force because he has not responded to its various requests for proof of earnings. Claimant contends that he qualifies for temporary disability compensation because he continued working until his compensable condition worsened requiring surgery. In support of his contentions, claimant's employer submitted a letter verifying that claimant was employed from February 6, 1998 to August 9, 1998. SAIF has not rebutted this submission. Instead, SAIF represents that, until it receives proof of claimant's earnings, its position remains that claimant was not in the work force at the time of his disability.

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).

Here, on May 11, 1998, Dr. Cronk, claimant's attending surgeon, recommended that claimant undergo arthroscopy on his right medial meniscus. Under such circumstances, claimant must establish that he was in the work force in May of 1998 (his "date of disability") when his condition worsened precipitating the surgery recommendation. *See Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Based on claimant's unrebutted submission, we are persuaded that he was in the work force as of the date of his disability. Consequently, we conclude that claimant has established that he was working at the time his compensable condition worsened requiring 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.

IT IS SO ORDERED.

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

In the Matter of the Compensation of
PETER VOORHIES, Claimant
Own Motion No. 97-0530M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the insurer's May 14, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from January 7, 1997 through March 25, 1998. The insurer declared claimant medically stationary as of March 25, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

In an July 15, 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. Having received the parties' submissions and respective positions, we proceed with our review.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 14, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In support of its closure, the insurer relies on an undated "fill-in-the-blanks" letter submitted by Dr. Winquist, claimant's treating physician, who had last examined claimant on November 1997. In response to the question "Is [claimant] presently medically stationary post total hip replacement surgery?," Dr. Winquist replied "Yes." Since the responsive letter was received by the insurer on March 25, 1998, that is the date the insurer apparently used as claimant's medically stationary date.

However, subsequent to the May 14, 1998 claim closure, Dr. Winquist examined claimant on June 10, 1998. He opined that claimant was gradually getting better and that he had strengthened "quite a bit." On August 18, 1998, Dr. Winquist authored a report withdrawing his prior opinion regarding claimant's medically stationary status. Dr. Winquist provided the following explanation:

> "While no further treatment/surgery is planned at this time, [claimant] does continues to make gradual improvements *** In March, 1998, a form to [the insurer] states [claimant] was medically stationary. This was incorrect in that he continues to the gradual improvements noted above."

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Winquist retracted his earlier opinion that claimant was medically stationary in March 1998 (which was rendered without an examination since November 1997) and opined that claimant's condition had materially improved since that examination. Dr. Winquist's August 18, 1998 opinion was based on a medical examination conducted on June 10, 1998, just three weeks after the insurer closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the May 1998 claim closure and Dr. Winquist's June 1998 examination, we conclude that Dr. Winquist's August 1998 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622.[1] Thus, based on Dr. Winquist's unrebutted opinion, we conclude that claimant was not medically stationary on May 14, 1998 when his claim was closed by the insurer.

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[1] We note that Dr. Winquist's "change" of opinion is somewhat conclusory. However, in light of Dr. Winquist's original opinion expressed in his one word "fill-in-the-blank" response to the insurer's medically stationary question, the August 1998 report is sufficiently explained to overcome the initial "fill-in-the-blank" opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

Therefore, we set aside the insurer's May 14, 1998 Notice of Closure. The claim is remanded to the insurer to recommence temporary disability benefits as of the date it previously terminated such benefits and to continue the payment of these benefits until they can be lawfully terminated. When it is appropriate, the claim shall be closed by the insurer pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL A. WHITNEY, Claimant
Own Motion No. 98-0416M
OWN MOTION ORDER DENYING CONSENT TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, Moore, et al, Claimant Attorneys
Liberty NW Ins. Corp., Insurance Carrier

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1992 injury claim with Liberty NW Insurance Corp. expired September 11, 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 contains no request for surgery for claimant's compensable lumbosacral strain and L5-S1 lumbosacral disc protrusion. Thus, the record fails to establish that there has been a worsening of the compensable injury which requires inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, based on this record, the Board may not authorize the payment of temporary disability compensation on its own motion.

Accordingly, the Board is without authority to consent to an order designating a paying agent for the purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. *See* OAR 436-060-0180(13).

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA L. GLOBE, Claimant
WCB Case No. 97-04038
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of claimant's aggravation claim for a right wrist condition. On review, the issue is aggravation.

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

On May 28, 1992, the insurer accepted a nondisabling right wrist strain. (Ex. 10). On May 10, 1994, the insurer denied claimant's claim for an anterior interosseous syndrome. (Ex. 40). On May 30, 1995, a prior ALJ[1] issued an order holding that, although claimant's current right wrist condition was compensable, the anterior interosseous nerve surgery proposed by Dr. Van Beek, treating physician, was not reasonable and necessary treatment for that condition. (Ex. 46). That order became final by operation of law.

Claimant's right wrist symptoms remained the same. On November 27, 1996, claimant underwent the proposed surgery, which was performed by Dr. Van Beek and was paid for by her private health insurance carrier. (Ex. 49, Tr. 11-12). Claimant filed an aggravation claim, which the insurer denied. (Ex. 55). Claimant requested a hearing, and the ALJ determined that claimant's aggravation claim, which was based solely on undergoing the proposed surgery, was barred by the res judicata doctrine of issue preclusion. We agree.

ORS 656.273(1) entitles an injured worker to "additional compensation for worsened conditions resulting from the original injury." The statute provides that a worsened condition is established by medical evidence of an "actual worsening" of the compensable condition supported by objective findings. An "actual worsening" is established by direct medical evidence that a condition has pathologically worsened. *SAIF v. Walker*, 145 Or App 294, 305 (1996).[2]

Here, claimant does not contend that her right wrist condition itself worsened, either pathologically or otherwise. To the contrary, claimant testified that her symptoms remained the same. (Tr. 10-11). Instead, claimant argues that "[t]he fact claimant had surgery on an accepted compensable condition, **by definition**, constitutes a worsening." (Claimant's Reply Brief, emphasis in original). In other words, claimant argues that, as a matter of law, undergoing the surgery constituted a worsening and established a compensable aggravation claim. In addition, claimant argues that, although the insurer was not liable for payment of the surgery itself due to the prior ALJ's finding that the surgery was not reasonable and necessary, the insurer is liable for the "aggravation" caused by undergoing the surgery, *i.e.*, the insurer is liable for any temporary or permanent disability that might result from the surgery.

We recently rejected a similar argument in a different context. In *Thomas E. Suby (Suby I)*, 50 Van Natta 718 (1998), while his claim was open, the claimant underwent a low back fusion surgery that had previously been determined by the Department as not reasonable and necessary treatment for the

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[1] At the time of that prior order, "ALJs" were identified as "Referees" and the Hearings Division had jurisdiction over issues involving the appropriateness of medical services. Subsequently, the legislature transferred jurisdiction over those issues to the Department. ORS 656.245; ORS 656.327.

[2] In *Walker*, after considering the text and context of *amended* ORS 656.273, together with the legislative history, the court concluded that, under the amended statute, in order for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. The court held that proof of a pathological worsening is required to establish a compensable aggravation claim under *amended* ORS 656.273.

compensable injury. The parties litigated the claimant's entitlement to procedural temporary disability benefits caused solely by that surgery. We concluded that the claimant was not entitled to those benefits pursuant to the res judicata doctrine of issue preclusion. *North Clackamas School Dist. v. White*, 305 Or 48, 53 (1988).[3]

In so ruling, we relied on the Department's final determination that the proposed fusion surgery was not appropriate for the compensable injury. We reasoned that the Department's final determination established that the surgery was not a compensable consequence of the injury and, therefore, precluded the claimant from asserting that the time loss he sustained as a result of the surgery was a compensable consequence of the accepted injury. We also noted that our ruling was consistent with the court's recognition, in the "consequential condition" context, that the reasonableness and necessity of treatment for an accepted injury is an essential link in the chain of compensability between the accepted injury and a subsequent injury suffered as a result of the treatment. *See Barrett Business Services v. Hames*, 130 Or App 190, *rev den* 320 Or 492 (1994) (where necessary and reasonable treatment of a compensable injury is the major contributing cause of a new injury, a distinction between the compensable injury and its treatment is artificial). By analogy, we concluded that the Director's final determination that the fusion surgery was not appropriate treatment for the accepted injury had broken the chain of causation between the accepted injury and time loss resulting from the inappropriate surgery.

Subsequently, following closure of the claimant's claim, the same parties litigated the claimant's entitlement to substantive temporary disability benefits following the surgery and increased unscheduled permanent disability based on an impairment value for the surgery itself. *Thomas E. Suby (Suby II)*, 50 Van Natta 1088 (1998). We held that the reasoning in *Suby I* also applied to those issues. Specifically, we found that issue preclusion barred the claimant's claims for substantive temporary disability and increased unscheduled permanent disability sustained as a result of the noncompensable surgery because the Director's final determination that the surgery was not appropriate treatment had broken the chain of causation between the accepted injury and the claimed temporary and permanent disability benefits. *Suby II*, 50 Van Natta at 1089.

Suby I concerned the claimant's entitlement to procedural temporary disability benefits on an open claim flowing from a surgery that had been finally determined to be inappropriate, and *Suby II* concerned the claimant's entitlement to substantive temporary disability benefits and permanent disability benefits for the same surgery upon closure of that claim. Notwithstanding this difference, we conclude that the rationale expressed in *Suby I* and *Suby II* is equally applicable here.

As stated above, "an injured worker is entitled to additional compensation for worsened conditions *resulting from* the original injury." ORS 656.273(1) (emphasis added). Here, claimant's sole argument is that undergoing the inappropriate surgery resulted in the required "worsened condition" to establish a compensable aggravation claim. However, the prior ALJ's final ruling that the surgery was not appropriate broke the requisite chain of causation and established an issue preclusion bar to any claim flowing from that surgery, including claimant's current aggravation claim. Thus, we conclude that claimant has not established a compensable aggravation claim based on the fact that she underwent a surgery that had been determined to be not reasonable and necessary.

ORDER

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

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[3] The rule of issue preclusion provides that, if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. *White*, 305 Or at 53.

In the Matter of the Compensation of
JOHN K. HARKNESS, Claimant
WCB Case No. 97-08467
ORDER ON REVIEW
Gayle A. Shields, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's current lumbar condition as procedurally improper; (2) awarded an assessed attorney fee pursuant to ORS 656.386(1) for setting aside the denial; and (3) awarded a penalty-related attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are the procedural propriety of the denial, attorney fees and penalty-related attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Procedural Propriety of SAIF's Denial

Claimant compensably injured his low back on November 29, 1996. SAIF accepted a lumbar strain. (Ex. 4). On August 25, 1997, SAIF denied compensability of claimant's current low back condition on the basis that his injury had ceased to be the major cause of the treatment and disability of the combined condition. (Ex. 24). On August 26, 1997, SAIF issued a Notice of Closure that found claimant's condition medically stationary on August 5, 1997 and declined to award any permanent disability. (Ex. 26). A January 5, 1998 Order on Reconsideration affirmed the Notice of Closure. (Ex. 30A).

The ALJ determined that SAIF had not accepted a combined condition and, therefore, ORS 656.262(7)(b) did not apply to the claim. The ALJ concluded that SAIF's denial was procedurally improper and should be set aside.

On review, SAIF argues that the ALJ incorrectly reasoned that determining the applicability of ORS 656.262(7)(b) depends on whether the carrier accepted a combined condition. SAIF contends that *Marianne L. Sheridan*, 48 Van Natta 908 (1996), remains the controlling precedent for determining the applicability of ORS 656.262(7)(b). SAIF asserts that the proper test is whether the carrier's *denial* was based on the presence of a preexisting condition, not whether the carrier *accepted* a combined condition.

After the ALJ's order, we decided *Tracey A. Blamires*, 50 Van Natta 1793 (1998). In that case, we disavowed *Robin W. Spivey*, 48 Van Natta 2363 (1996), and its progeny to the extent that those cases held that ORS 656.262(7)(b) applies only if the carrier has expressly accepted a combined condition. We concluded 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 carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b). In other words, 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.

Although the record does not establish that SAIF *accepted* a combined condition,[1] the medical evidence establishes that claimant's accepted injury combined with a preexisting condition to cause or

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[1] Claimant injured his low back on November 29, 1996 and sought emergency room treatment on December 2, 1996. (Ex. 3). Dr. Blackthorne diagnosed a lumbar strain and prescribed medication. (*Id.*) He did not order x-rays. (Ex. 2). Although Dr. Blackthorne mentioned that claimant had previously experienced mild low back strains, he did not comment as to whether claimant had any degenerative conditions. We find no evidence in the record to indicate that SAIF accepted a combined condition when it accepted a lumbar strain on December 19, 1996.

prolong disability or a need for treatment. The first reference in the record to a degenerative back condition was on February 6, 1997, when Dr. Ward recommended lumbosacral spine x-rays to rule out degenerative disc and joint disease. (Ex. 7-4). X-rays on the same date indicated claimant had mild narrowing at L4-5 and L5-S1 and probable degenerative facet changes at the L5-S1 junction. (Ex. 8). On March 31, 1997, Dr. Ward opined that claimant had degenerative disc and joint disease at L4-5 and L5-S1 that preexisted his injury and combined with his lumbosacral strain to cause or prolong his disability and need for treatment. (Ex. 11).

Dr. Dinneen examined claimant on behalf of SAIF and diagnosed a lumbar strain, superimposed on preexisting degenerative changes. (Ex. 21-4). His opinion is consistent with Dr. Ward's opinion that claimant's injury combined with the preexisting degenerative condition to cause or prolong his disability and need for treatment. In addition, Dr. Harris agreed that claimant's diagnosis was lumbosacral strain, superimposed on degenerative disc disease. (Ex. 23-1). Based on these medical opinions, we conclude that ORS 656.005(7)(a)(B) applies to this case.

On August 25, 1997, SAIF denied compensability of claimant's current low back condition on the basis that his injury had ceased to be the major cause of the treatment and disability of the combined condition. (Ex. 24). *See* ORS 656.262(7)(b).[2] Thus, we must examine the medical evidence to determine compensability of claimant's current condition.

Claimant injured his low back on November 29, 1996. Dr. Ward referred to the "work-related" diagnosis as lumbosacral strain and the "non-work related" diagnosis as mild degenerative disc and joint disease at L4-5 and L5-S1. (Exs. 8A, 8B, 9A). On March 31, 1997, Dr. Ward explained that claimant had degenerative disc and joint disease at L4-5 and L5-S1 that preexisted his injury and combined with his lumbosacral strain to cause or prolong his disability and need for treatment. (Ex. 11-1). At that time, Dr. Ward believed that the November 29, 1996 injury was, and remained, the major contributing cause of the combined condition and need for treatment. (*Id.*) Dr. Ward anticipated that the "preexisting condition would become the major cause of the combined condition and need for treatment within the next two months." (Ex. 11-2).

Dr. Ward performed a closing medical examination on August 8, 1997. (Ex. 22). He continued to refer to the "work-related" diagnosis as lumbosacral strain and the "non-work related" diagnosis as mild degenerative disc and joint disease at L4-5 and L5-S1. (Ex. 22-3).

Following an August 5, 1997 examination, Dr. Dinneen opined that claimant's preexisting degenerative disc disease "is now considered to be the main contributing cause of the symptoms and perceived impairment." (Ex. 21-4). Dr. Dinneen explained that the accepted lumbar strain was originally "the major contributing cause of the need for treatment and this would persist for up to three months following the incident." (*Id.*)

On December 26, 1997, Dr. Ward said that he concurred with Dr. Dinneen's report, except for a few points. He explained:

> "I believe the *preexisting condition* prolonged the need for treatment beyond the three months suggested by Dr. Dinneen. This is a relatively common problem. Strains without preexisting condition generally last three months but sometimes longer. Preexisting conditions often prolong the need for treatment far beyond the three months." (Ex. 30-1; emphasis added).

Although Dr. Ward felt that claimant's preexisting condition had prolonged the need for treatment beyond three months, he did not disagree with Dr. Dinneen's conclusion that the preexisting degenerative disc disease "is now considered to be the main contributing cause of the symptoms and perceived impairment." (Ex. 21-4). Furthermore, although Dr. Ward's March 31, 1997 report indicated that the November 29, 1996 injury was the major contributing cause of the combined condition and need

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[2] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

for treatment, he did not make any such comments in the August 8, 1997 closing examination or in his letter responding to Dr. Dinneen's report. We note that Dr. Ward had anticipated on March 31, 1997 that claimant's preexisting condition would become the major cause of the combined condition and need for treatment within the next two months, *i.e.*, by approximately May 31, 1997. (Ex. 11-2).

After reviewing the medical evidence, we are persuaded by Dr. Dinneen's report that claimant's preexisting degenerative condition is the major contributing cause of his current low back condition. Consequently, we uphold SAIF's partial denial of the current low back condition.

The ALJ awarded claimant's attorney a $3,000 attorney fee under ORS 656.386(1). Because claimant did not prevail against SAIF's partial denial of the current low back condition, he is not entitled to an attorney fee pursuant to ORS 656.386(1).

The ALJ assessed a penalty-related attorney fee pursuant to ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. We have found that the underlying claim is not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated March 18, 1998, as reconsidered May 4, 1998, is reversed. SAIF's partial denial of claimant's current low back condition is reinstated and upheld. The ALJ's attorney fee award and penalty-related attorney fee under ORS 656.382(1) are reversed.

In the Matter of the Compensation of
TAMERA ROSE, Claimant
Own Motion No. 95-0329M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's June 2, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from September 12, 1995 through May 23, 1998. The employer declared claimant medically stationary as of April 24, 1998. Submitting a copy of the Notice of Closure, claimant states that she is "requesting for a review of [her] claim."

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 June 2, 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 June 19, 1998 letter, we requested that the parties 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 June 24, 1998, however, no further response has been received from claimant. Therefore, we will 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, we interpret claimant's request "for review of [her] claim" as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On April 24, 1998, claimant was examined by Drs. Reimer and Thomas at the employer's request. They opined that claimant was medically stationary and "no recommended treatment plan is given." Dr. Booth, claimant's treating physician, concurred with Drs. Reimer's and Thomas' opinion on May 13, 1998. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on April 24, 1998. Inasmuch as temporary disability was paid through May 23, 1998 and that the claim was closed on June 2, 1998, we conclude that claimant is not entitled to additional temporary disability and that the employer's closure was proper.

Accordingly, we affirm the employer's June 2, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Hernandez*, 155 Or App 401 (1998). The court reversed our prior order, *Jose L. Hernandez*, 47 Van Natta 1030 (1997), that reduced claimant's unscheduled permanent disability award for a gastrointestinal condition from 37 percent (118.4 degrees) to 36 percent (115.2 degrees). Concluding that we failed to evaluate claimant's condition as of the date of the reconsideration order, the court has remanded for reconsideration.

FINDINGS OF FACT

As part of claimant's compensable left arm injury, the SAIF Corporation accepted "peptic duodenal ulcer disease secondary to the use of NSAIDS." (Ex. 14). A Notice of Closure awarded 9 percent scheduled permanent disability for the left arm and 18 percent unscheduled permanent disability for the left shoulder. An Order on Reconsideration increased the unscheduled permanent disability award to 25 percent and otherwise affirmed the Notice of Closure. The increase in part was based on the finding that claimant was entitled to 3 percent impairment for his peptic ulcer disease.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was entitled to impairment under Class 2 of *former* OAR 436-035-0420(2) (WCD Admin. Order 96-051) and increased the unscheduled permanent disability award to 37 percent. Based on different reasoning, we agreed that claimant was entitled to such impairment but, after calculating the factors, modified the award to 36 percent. As previously noted, the court has reversed and remanded.

Under *former* OAR 436-035-0420(2), impairment of the upper digestive tract, including the duodenum, is valued according to four classes; only the first two are relevant in this case. Class 1 provides:

> "Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; and
>
> "Continuous treatment is not required; and

"Weight can be maintained at the desirable level; or

"There are no sequelae after surgical procedures."

Class 2 provides:

"Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and

"Appropriate dietary restrictions and drugs are required for control of symptoms, signs and/or nutritional deficiency; and

"Loss of weight below the 'desirable weight' [provided in the standards] does not exceed 10%."

On review, we construed Class 2 as requiring proof of a weight loss that did not exceed 10 percent of claimant's desirable weight. We further decided that claimant satisfied such a showing because he experienced a weight loss of 145 pounds to 137 pounds. Thus, after also finding that claimant continued to experience symptoms from his peptic ulcer disease and was required to follow dietary restrictions and use prescription medication to control the symptoms, we concluded that he proved entitlement to impairment under Class 2.

On judicial review, the court agreed with SAIF that the rule must be applied in light of ORS 656.283(7), which provides that "[e]valuation of the worker's disability * * * shall be as of the date of issuance of the reconsideration order[.]" Specifically, the court found that we "failed to evaluate claimant's condition as of the date of reconsideration" and, thus, erred. 155 Or App at 406. The court also rejected claimant's argument that the rule does not require proof of weight loss, finding that such a construction was not consistent with the rule. *Id.*

Pursuant to the court's decision, we evaluate claimant's condition as of the date of the reconsideration order. In particular, in order to be entitled to Class 2 impairment under *former* OAR 436-035-0420(2), claimant must show, in part, a weight loss "below the 'desirable weight' [provided in the standards that] does not exceed 10%" as of the issuance of the reconsideration order. The record shows that, in November 1995, claimant had gained weight from the time he first began experiencing upper digestive tract symptoms. (Ex. 9A). Thus, when the Order on Reconsideration issued, claimant had sustained a weight gain rather than a weight loss. Because claimant did not prove a weight loss as of the date of the reconsideration order, he is not entitled to Class 2 impairment under *former* OAR 436-035-0420(2). Rather, as indicated by his treating physician, claimant is entitled to Class 1, or 3 percent, impairment. (Ex. 7).

The parties do not disagree with the Order on Reconsideration finding entitlement to 2 percent impairment for the shoulder condition and that this impairment, combined with 3 percent, results in 5 percent impairment. The parties also do not contest the values of 5 for age and education and 4 for adaptability. Multiplying the age and education values with adaptability results in a value of 20 percent. *Former* OAR 436-035-0280(6). Adding that value to the impairment value of 5 results in 25 percent. *Former* OAR 436-035-0280(7). Thus, claimant is entitled to an award of 25 percent unscheduled permanent disability.

On reconsideration of our prior orders, the ALJ's order dated September 20, 1996 is reversed. The Order on Reconsideration awarding 25 percent (80 degrees) unscheduled permanent disability is affirmed. The ALJ's attorney fee award is reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANE C. LEONETTI, Claimant
WCB Case No. 97-10152
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that awarded 3 percent (9.6 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

On review, claimant contends, among other things, that she is entitled to additional unscheduled permanent disability based on social/vocational factors because she did not return to unrestricted regular work. As set forth below, we disagree. We find that claimant was released and returned to her "regular work," and is therefore not entitled to a value for social and vocational factors. *See* ORS 656.726(3)(f)(D); OAR 436-035-0270(3) (WCD. Admin. Order 96-072) (social/vocational factors are not available to injured workers who return to "regular work").

At the time of her April 1996 injury, claimant was working as a "surgical prep" registered nurse. (Ex. 3). In May 1997, claimant's attending physician, Dr. Rabie, released her to perform her regular job, provided that she not exceed the demonstrated weight lifting capacities identified by her physical capacities evaluation (PCE).[1] (Ex. 26-1). Around this same time, both claimant and her supervisor indicated that, considering the results of the PCE, claimant was capable of performing her regular job as a registered surgical prep nurse.[2] (Ex. 26). Similarly, on May 16, 1997, Dr. Staver determined that claimant could and, in fact, had returned to her regular job in the surgical prep unit.[3] (Ex. 27-10).

Pursuant to OAR 436-035-0005(17), "regular work" means "the job the claimant was doing at the time of injury or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." Here, although claimant does have certain identified physical restrictions, the record does not demonstrate that these restrictions required a modification of her job duties. On the contrary, the evidence establishes that claimant was released to, and returned to, her regular job as a "surgical prep nurse." Indeed, although claimant's physical restrictions may require a change in the way she performs certain duties (*i.e.*, requesting assistance on those infrequent occasions when she is required to lift or transfer more than 25 pounds), we are persuaded that she remains capable of performing the same job she was doing at the time of her injury. Consequently, her unscheduled permanent disability award was properly limited to permanent, injury-related impairment only. *See, e.g., James I. Dorman*, 50 Van Natta 1649, *on recon* 50 Van Natta 1773 (1998) (although the claimant modified the manner in which he performed his truck driving job, he was released to full duty as a truck driver and returned to his "regular work," as he was performing the same duties and responsibilities as his job at the time of injury); *Margaret S. Morgan*, 49 Van Natta 1934, *on recon*, 49 Van Natta 2072 (1997) (where the claimant was performing substantially the same job, and the record did not establish any change in job duties from those which the claimant performed prior to her injury, Board found that the claimant returned to

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[1] The PCE indicated that claimant could frequently lift and carry up to 10 pounds, occasionally lift and carry up to 25 pounds and rarely lift and carry more than 26 pounds. (Ex. 26-2).

[2] According to the job analysis for a "surgical prep" nurse, the physical demands vary, but lifting and carrying is generally under 25 pounds. At times, the nurse may do a one to three person patient lift and, approximately two to three times a month, be required to lift more than 25 pounds with a patient/wheelchair transfer. (Ex. 26-3).

[3] Dr. Staver examined claimant at the employer's request. In June 1997, Dr. Rabie concurred with Dr. Staver's report (Ex. 29), so his findings may be considered in evaluating claimant's disability. *See Tektronix, Inc. v. Watson*, 132 Or App 483, 487 (1995) (consulting physician's impairment findings admissible for purposes of evaluating impairment when ratified by attending physician).

"regular work" and was not entitled to a value for age, education and adaptability factors); *cf. Barbara J. Burns*, 50 Van Natta 1818 (1998) (where the evidence established that the claimant's duties had been modified in accordance with her medical restrictions, she did not return to "regular" work); *Jeri L. Hanson*, 50 Van Natta 1047 (1998) (the claimant's restriction from repetitive use of the right arm required a change in the claimant's custodial job duties, and not just a change in the manner the claimant performed those duties, thereby entitling the claimant to a value for social and vocational factors).

ORDER

The ALJ's order dated April 30, 1998 is affirmed.

October 19, 1998 Cite as 50 Van Natta 2061 (1998)

In the Matter of the Compensation of
ROBERTA J. LINDBERG, Claimant
WCB Case No. 97-07779
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Bruce Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's arguments on review.

The ALJ upheld the employer's denial, finding that the medical opinions of Drs. Wilken and Brooks, who addressed the causation of claimant's bilateral CTS, failed to establish that claimant's work activities (driving a car and some computer keyboard work) were the major contributing cause of this condition or its worsening. On review, claimant contends that Dr. Wilken's and Dr. Brooks' opinions establish that the symptoms of bilateral CTS are the disease and that her work activity was the major contributing cause of this condition. For the following reasons, we disagree with claimant's contentions.

Based on objective findings of bilateral slowing of claimant's median nerves, Dr. Brooks and Dr. Wilken diagnosed bilateral CTS. (Exs. 6-3, 8-5, 13-12). Neither doctor, however, attributed the major contributing cause of claimant's CTS to her work activities. Dr. Brooks stated unequivocally that the cause of claimant's CTS was idiopathic. (Exs. 6-3, 12-19). After evaluating the several factors bearing a causal relationship to claimant's CTS condition, Dr. Wilken stated that she was unable to establish that claimant's work contributed more than 50 percent to her CTS. (Ex. 13-29, -30).[1] Finally, neither doctor provided any medical evidence that claimant's employment activities caused a pathological worsening of claimant's CTS. Therefore, even if we were to assume that the symptoms of claimant's CTS are the disease, claimant has failed to prove medical causation. Therefore, claimant's bilateral CTS is not compensable.

ORDER

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

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[1] Dr. Wilken's statement that the precipitating cause of claimant's CTS symptoms during the day was her driving is insufficient to establish that the major contributing cause of her CTS was her work. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (the fact that a work injury precipitated a claimant's symptoms or condition does not necessarily mean that the injury was the major contributing cause of the condition). Moreover, Dr. Brooks' statement that claimant's "driving work activity was the major cause for the need for treatment" is insufficient to establish compensability of her CTS, as Dr. Brooks opined that the sole cause of claimant's CTS condition was idiopathic.

In the Matter of the Compensation of
WALTER C. WINDOM, Claimant
WCB Case No. TP-98002
INTERIM THIRD PARTY ORDER
Stebbins & Coffey, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Bock.

In connection with the SAIF Corporation's petition to the Board to resolve a dispute concerning the "just and proper" distribution of proceeds from a third party settlement under ORS 656.593(3), claimant has moved to compel production of certain SAIF claim files concerning claimant, including any "third party claim file." Specifically, relying on ORS 40.375 (Oregon Rule of Evidence 612), claimant seeks to discover the claim file documents reviewed by SAIF's third party claims adjuster, Peggy Millican, in preparation for her affidavit and deposition regarding the third party dispute. In response, SAIF contends the requested documents have already been produced and that any remaining documents in SAIF's third party and claim files are otherwise privileged and not discoverable.

For the reasons set forth herein, we refer this matter to the Hearings Division for assignment to an Administrative Law Judge (ALJ) to conduct a discovery conference and an "in camera" review of SAIF's files on claim Nos. 4749224F and 7749029J as well as the Third Party Unit claims file concerning claimant. The ALJ is to determine which claim file documents pertain to the parties' dispute and whether any of the documents which have not yet been produced are privileged or otherwise protected from disclosure under the Board's discovery rules. Thereafter, the ALJ shall issue an appropriate order on discovery.

FINDINGS OF FACT

At all pertinent times, claimant worked as a loading operator for SAIF's insured. In August 1985, he made a clam for a disc injury that occurred in 1983. SAIF designated this claim as claim number 449224F and, on December 6, 1985, accepted claimant's degenerative disc disease as a nondisabling condition.

Claimant's back condition worsened and, in January 1989, he wrote to SAIF asking that his claim be reopened. SAIF submitted claimant's request to the Board's own motion section and the claim was reopened as a worsening of the 1983 industrial injury pursuant to a March 3, 1989 Own Motion Order.

In November 1990, claimant filed another claim contending that his January 1989 incident was a new injury rather than a continuation of his 1983 claim. SAIF assigned this new claim No. 7749029J and issued a letter denying that claimant had experienced a new injury or occupational disease. Claimant requested a hearing on the denial. In addition, claimant contended that his 1983 claim was improperly designated as nondisabling.

In July 1992, the parties entered into a Disputed Claim Settlement with regard to claim No. 7749029J (the new injury claim). In exchange for SAIF's payment of $13,000, claimant specifically agreed that he did not experience a new injury in 1988 or 1989 and that his condition remained a continuation of his May 1983 injury. The parties also agreed that SAIF's denial of the new injury remained in full force and effect. An ALJ approved the stipulated settlement and dismissed claimant's request for hearing with prejudice on July 17, 1992.

Meanwhile, on February 26, 1992, claimant underwent a lumbar myelogram. He experienced complications from the procedure, including increased pain and weakness in his right leg, and was hospitalized for two days. Thereafter, claimant was unable to return to work because of his increased symptoms.

On July 30, 1992, the Board issued an Own Motion Order finding that claimant's 1983 compensable injury had worsened requiring hospitalization. The Board ordered that the claim be reopened for payment of temporary total disability compensation beginning February 26, 1992. SAIF closed the Own Motion claim on December 2, 1993, deeming claimant medically stationary as of November 16, 1993.

On or about February 18, 1994, claimant filed a third party action against the doctors and hospital responsible for his myelogram, alleging that he suffered permanent injuries as a result of the defendants' negligence.

In January 1995, claimant's third party counsel faxed a copy of claimant's third party complaint to SAIF's Third Party Unit. In April 1995, claimant's third party counsel contacted SAIF to determine the amount of SAIF's third party lien. One of SAIF's claims adjusters, Dan Willey, advised claimant's counsel that claim No. 774902J had been resolved through a DCS and that there were no liens associated with that claim. Claimant's counsel did not communicate with any other SAIF adjusters at this time, and was unaware of any liens associated with claim No. 4749224F.

At some point prior to September 1995, the third party medical malpractice suit was settled for the sum of $75,000. The settlement proceeds were distributed and, after deducting costs and attorney fees, claimant received $40,000.

On September 1, 1995, Rica Brooks, one of SAIF's Third Party Claim Adjusters, wrote to claimant's third party counsel advising, among other things, that should any third party action be filed, SAIF had a lien on any cause of action regarding claim No. 4749224F. On September 8, 1995, claimant's third party counsel advised SAIF that claimant did not currently have a third party action pending, that the medical negligence claim had recently settled and that, while negotiating the settlement, claimant's counsel had contacted SAIF and understood that SAIF would not be asserting a lien on the proceeds.

In July 1996, SAIF advised claimant's counsel that it could find no documentation supporting claimant's counsel's contention that he had been advised by a SAIF representative that SAIF did not intend to pursue a lien in the third party action. Claimant responded by providing copies of his correspondence with Dan Willey and explaining that he did not realize that SAIF had two claim numbers and that Mr. Willey was only referring to one of the two claims.

On February 12, 1998, SAIF petitioned the Board seeking to resolve a dispute concerning its entitlement to a "just and proper" distribution of proceeds from the third party settlement. Specifically, SAIF contended that, as a result of complications from claimant's February 1992 myleogram, it incurred medical costs and temporary disability costs in excess of $42,000. SAIF sought recovery of $28,918 as its "just and proper" share of the settlement proceeds.

On May 8, 1998, the parties deposed Peggy Millican, the SAIF third party adjuster currently assigned to this case. Ms. Millican had signed an affidavit in connection with SAIF's petition stating, among other things, that she had reviewed "SAIF's third party file" as well as "claim file 4749224F in its entirety" and had found no indication that claimant's counsel had contacted SAIF's third party unit to determine whether SAIF intended to assert a lien with regard to claim No. 4749224F. In her deposition, Ms. Millican testified that she had again reviewed the "third party file," and the claim No. 4749224F file to prepare for her deposition. She further testified that she had previously reviewed claim file No. 7749029J on two separate occasions, although she did not do so just prior to her deposition.

At the deposition, claimant's attorney requested production of the third party claim file documents that Ms. Millican reviewed in connection with her affidavit and deposition, as well as documents from claim file Nos. 4749224F and 7749029J. When SAIF's counsel declined to produce certain documents on the grounds such documents were privileged, claimant sought an order compelling production of these documents from the Board.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.593(3) the Board has jurisdiction to resolve the dispute arising out of the "just and proper" distribution of the proceeds from claimant's third party legal malpractice settlement. Our order must be made upon a record sufficient to sustain judicial review under ORS 656.298. *See Blackman v. SAIF*, 60 Or App 446, 448 (1982). In exercising our authority in the third party context, it is not unprecedented for us to refer a matter to the Hearings Division for a fact finding hearing. *See Nova Y. Knutzen*, 40 Van Natta 1825 (1988). Similarly, when workers' compensation litigants become embroiled in a pre-hearing discovery dispute, it is not unprecedented for the presiding ALJ to refer the matter to an ALJ (who is not assigned to hear the case on the merits) to conduct an "in camera" review of documents claimed to be privileged and decide which documents are discoverable. *See, e.g. Abraham Heamish*, 42 Van Natta 785 (1990).

Here, claimant contends that pursuant to ORS 40.375 (Oregon Evidence Code Rule 612),[1] he is entitled to discover the documents Ms. Millican reviewed in anticipation of her February 11, 1998 affidavit and her May 8, 1998 deposition. Specifically, claimant seeks to review SAIF's entire "third party claim file" as well as the contents of SAIF claim file Nos. 4749224F and 7749029J. Claimant argues that, although the Board and Hearings Division are not bound by common law or statutory rules of evidence, we should nevertheless rely on Rule 612.

In response, SAIF contends that, to the extent Rule 612 is applicable, it has already produced any documents from the claim files that Ms. Millican may have used to refresh her memory[2] and that, insofar as certain claim file documents have not been produced, those documents are protected by the attorney-client or work product privilege.

As claimant acknowledges, we are not bound by the Evidence Code and have no obligation to apply Rule 612 to the parties' third party dispute. Furthermore, even if Rule 612 were applicable, the rule does not permit unfettered access to the opponent's files; it only allows for the production of documents that are used to refresh memory "if the court in its discretion determines it is necessary in the interests of justice."

In exercising our discretion to resolve this discovery dispute, we look not to the Oregon Evidence Code but rather to the Board's own discovery rules for guidance. Under the current rules, the parties are entitled to discovery of "documents pertaining to the claim(s)." OAR 438-007-0015(5) (WCB Admin. Order 3-1997). The Board's rules further provide that certain documents pertaining to the claim are not discoverable, including material protected under the attorney/client privilege, attorney work product and material reflecting the mental impressions, case value or merit, plans or thought processes of the claimant or insurer. *See* OAR 438-007-0015(7).

Consequently, to the extent that Ms. Millican reviewed, in preparation for her affidavit and in anticipation of her deposition, certain claim file documents which pertain to the parties' dispute and which are not the type of material specifically protected from discovery under the Board's rules, claimant is entitled to discovery of those documents. Because this discovery matter is in dispute, and to ensure that claimant obtains complete discovery of the non-privileged materials in SAIF's claim files, the following actions shall be taken.

This matter is referred to the Hearings Division for assignment to an ALJ to conduct a discovery conference and an "in camera" review of the contents of SAIF claim file Nos. 4749224F and 7749029J and the Third Party Unit claim file concerning claimant. Once the parties are contacted by the assigned ALJ, we direct SAIF to submit copies of the documents reviewed by Ms. Millican to the ALJ for review. The ALJ shall determine which documents are discoverable (under OAR 438-007-0015 and the guidelines discussed above) and order discovery of such material to the extent the document has not already been produced. Those documents that are deemed not discoverable shall remain in the file, but shall be placed in a sealed envelope. Thereafter, should the parties determine that further depositions are necessary, they may proceed with them subject to the ALJ's prior "discovery" determinations.

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[1] ORS 40.375 provides in pertinent part:

"If a witness uses a writing to refresh memory for the purpose of testifying, either while testifying or before testifying if the court in its discretion determines it is necessary in the interests of justice, an adverse party is entitled to have the writing produced at the hearing, to inspect it, to cross-examine the witness thereon, and to introduce into evidence those portions which relate to the testimony of the witness. If it is claimed that the writing contains matters not related to the subject matter of the testimony, the court shall examine the writing in camera, excise any portions not so related, and order delivery of the remainder to the party entitled thereto. Any portion withheld over objections shall be preserved and made available to the appellate court in the event of an appeal. If a writing is not produced or delivered pursuant to order under this section, the court shall make any order justice requires . . . ."

[2] In response to claimant's motion, Ms. Millican has submitted an additional affidavit identifying the portions of the third party claim file she reviewed in anticipation of her deposition. She has averred that she did not review any file notes regarding her conversations with SAIF's counsel, or any documents concerning claim reserves or other proprietary information from the claim file to refresh her memory prior to the deposition.

We retain jurisdiction over the third party dispute. Following the discovery conference, the ALJ's "in camera" review and discovery order, and the completion of the parties' discovery efforts, the parties should notify the Board that they wish to proceed with the briefing schedule. Thereafter, the Board will re-implement a briefing schedule. On completion of that schedule, the Board will proceed with review of SAIF's petition for a share of the third party settlement proceeds.

IT IS SO ORDERED.

October 19, 1998 Cite as 50 Van Natta 2065 (1998)

In the Matter of the Compensation of
CAROL OCHS, Claimant
Own Motion No. 98-0224M
OWN MOTION ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys

Claimant requests reconsideration of our September 17, 1998 Own Motion Order on Reconsideration, in which we adhered to and republished in its entirety our July 14, 1998 order which 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 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
DAN BELLON, Claimant
WCB Case No. 95-13453
SECOND ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On October 12, 1998, we issued our Order on Remand that reversed an Administrative Law Judge's (ALJ's) order that: (1) directed the insurer to reinstate claimant's temporary total disability (TTD); and (2) assessed a penalty for the insurer's allegedly unreasonable termination of TTD. Applying *Liberty Northwest Ins. Corp. v. Jensen*, 150 Or App 548 (1997), we concluded that the insurer's termination of claimant's TTD was justified under *former* OAR 436-60-030(5). In reaching this conclusion, we found that claimant's employer had complied with the administrative rule in extending a modified job offer to him, which warranted the termination of claimant's TTD when he did not accept the offer and begin the modified employment.

Challenging our determination that "there is no contention that the employer actually knew the job's duration and withheld it from claimant," claimant seeks reconsideration of our decision. Asserting that the insurer has the "initial burden of coming forward with evidence that they do not know the job duration to support their failure to state the duration," claimant contends the insurer failed to satisfy this burden and, consequently, its termination of TTD benefits was not justified.

After re-reviewing the hearing transcript and the parties' appellate briefs, we continue to find no allegation that the employer actually knew the job's duration and withheld such information from claimant.[1] Nonetheless, because we would reach the same ultimate conclusion regardless of whether such an allegation was raised, we proceed with our reconsideration as if the contention has been made.

The record regarding this issue consists of the employer's modified job offer to claimant. In that offer, the employer advised claimant that the "continued availability of this position will be re-evaluated periodically." (Exhibit 11). Such a statement does not support a conclusion that the employer actually knew the duration of the modified job. To the contrary, the employer's references to "periodic re-evaluation" and "continued availability" indicate that the job's duration was unknown.

Inasmuch as there is no countervailing evidence rebutting the statements in the employer's modified job offer, we find that the record does not establish that the employer actually knew the job's duration and withheld it from claimant.[2] Consequently, on reconsideration, we continue to find that the insurer's termination of claimant's TTD benefits was warranted.

Accordingly, we withdraw our October 12, 1998 order. On reconsideration, as supplemented, we republish our October 12, 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 noted by claimant, the ALJ's opinion contains the following statement: "The evidence does not establish that the employer did not know the duration of the job." Although the comment undeniably pertains to the employer's knowledge (or lack thereof) of the duration of the modified job, neither that statement nor any other portion of the hearing record or appellate record supports a conclusion that there was a *contention* that the employer actually knew the duration of the modified job and withheld it from claimant. In any event, in addressing claimant's motion for reconsideration, we have assumed that such a contention has been raised.

[2] Because we would reach this same conclusion regardless of which party had the "burden of coming forward," we need not resolve this procedural issue. Nonetheless, whenever such an issue requires resolution, the litigants will be required to address the applicability of ORS 656.266, which provides that "[t]he 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.*" (Emphasis supplied.)

In the Matter of the Compensation of
DONALD CONVERSE, Claimant
WCB Case No. 96-07686
SECOND ORDER ON REMAND
Neil W. Jackson & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant has requested reconsideration of our September 28, 1998 Order on Remand. Specifically, claimant contends that, in addition to the $2,766.25 awarded by the Court of Appeals, his counsel is entitled to $5,260 for services at hearing and on Board review. Having considered claimant's request for reconsideration and statement of services as well as the insurer's response, we proceed to a determination of a reasonable attorney fee award.

Where 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. ORS 656.388(1); *Mark L. Hadley*, 47 Van Natta 725 (1995). Although statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum (because claimant did not finally prevail until the issuance of the Order on Remand), the court already granted claimant a $2,766.25 fee for services rendered on judicial review, conditioned on claimant prevailing on remand.

Neither party challenges the statutory basis for the court's attorney fee award for services on judicial appeal. In any event, after considering the factors set forth in OAR 438-015-0010(4), we would find that the court's $2,766.25 award represents a reasonable fee for claimant's counsel's services performed before that forum.[1]

We next turn to a determination of a reasonable fee for claimant's counsel's services at hearing and on Board review. Claimant requests $5,260, based upon 29.2 hours of attorney time and 2 hours of paralegal time. We note, however, that claimant's counsel is not entitled to recover paralegal time as part of his attorney fee, as such time is considered a cost. *See, e.g., Candace L. Spears*, 47 Van Natta 2393, 2394 (1995). In addition, claimant's counsel is not entitled to recover fees for services concerning issues of attorney fees and costs. *See Amador Mendez*, 44 Van Natta 736 (1994). With these two exceptions, we accept claimant's counsel's statement of services and find the time spent at the hearing and Board levels to be reasonable.

The hearing took approximately two and a half hours and involved four witnesses, three of whom were presented by claimant. The record included 28 exhibits, at least eleven of which were submitted by claimant. The case involved factual issues centering on claimant's credibility and participation in a workplace altercation and legal issues regarding the "active participant" exception to compensability. These issues were more complex than those normally presented to this forum for resolution. On Board review, claimant's counsel submitted an 11 page appellant's brief as well as a request for abatement and reconsideration.

The value of the interest involved in this case is significant in that claimant will likely receive compensation for medical services, temporary disability and, potentially, permanent disability for his compensable injuries. As demonstrated by the extent of litigation as well as the legal and factual issues addressed in the majority and dissenting opinions, there was a significant risk that claimant's counsel's efforts would go uncompensated. Finally, we note that the attorneys advocated their respective cases in a professional manner.

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[1] In its response to claimant's motion, the insurer objects to the awarding of attorney fees on the grounds this matter is not yet final. We reject this contention, because a represented claimant's entitlement to assessed attorney fees under ORS 656.386(1) is the "natural derivative" of a determination that the claimant prevailed over a denied claim. *See, e.g., Terry R. Myers*, 48 Van Natta 1039 (1996); *Frank P. Heaton*, 44 Van Natta 2104, 2106 (1992). A represented claimant is not required to "preserve" entitlement to attorney fees as a separate issue until the compensability determination becomes final by operation of law. Rather, where, as here, the represented claimant ultimately prevails over a denial, his entitlement to an assessed attorney fee for his counsel's efforts is an automatic result of the compensability determination. *Id.*

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on Board review is $4,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's appellate arguments to the Board, and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated. This award is in addition to the $2,766.25 awarded for services performed before the court, resulting in a total award for services rendered before all prior forums of $7,566.25, to be paid by the insurer.

In conclusion, on reconsideration, we find that a reasonable attorney fee award for claimant's counsel's services at all levels (including judicial review) is $7,566.25 payable by the insurer. Accordingly, the Board's September 28, 1998 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our September 28, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.[2]

IT IS SO ORDERED.

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[2] We acknowledge that the insurer has filed a petition for judicial review of our September 28, 1998 order. But, even though appealed, we retain jurisdiction to reconsider our original order for 30 days from the date of mailing of that order. *See* ORS 656.295(8); ORS 656.298(1); *Haskell Corporation v. Filippi*, 152 Or App 117 (1998) (Although a petition for judicial review of a Board order had already been filed when the Board withdrew its order within 30 days of the order's mailing, the Board retained authority to issue a reconsideration order).

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case No. 98-02326
ORDER OF ABATEMENT
Bottini, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our September 24, 1998 order that upheld the insurer's March 17, 1998 partial denial of his current disability and/or need for treatment. In addition, claimant requests that this case be consolidated with WCB Case No. 98-04194, which concerns the insurer's May 22, 1998 denial of claimant's current combined condition. Specifically, claimant contends that, in the original order, the Board erred in finding the insurer's March 17, 1998 denial procedurally appropriate under ORS 656.262(7)(b). Claimant asserts that both the March 17, 1998 and May 22, 1998 denials are procedurally invalid.

In order to further consider claimant's motions, we withdraw our September 24, 1998 order. We implement the following supplemental briefing schedule regarding claimant's consolidation motion as well as the substantive issues in both cases: The insurer's supplemental response must be filed within 14 days from the date of this order. Claimant's supplemental reply must be filed within 14 days of the mailing of the insurer's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
VICTOR M. FOSTER, Claimant
WCB Case No. 98-02227
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of claimant's injury or occupational disease claim for a low back condition. In addition, claimant moves the Board for an order remanding the case to the ALJ for the admission of additional evidence. On review, the issues are remand and compensability.

We adopt and affirm the ALJ's order, with the following supplementation regarding claimant's motion to remand.

At hearing, the ALJ declined to grant claimant's request that the June 9, 1998 hearing be continued or that the record be held open for one week for additional reports he had requested but not received from his attending physicians, Dr. Harper and Dr. Olson.[1] On review, claimant contends that the ALJ abused his discretion in denying his request to continue the hearing and requests remand for the admission of additional evidence, namely a report dated June 8, 1998 from Dr. Olson.[2]

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, even if claimant has established why Dr. Olson's report was unobtainable with due diligence at the time of the June 9, 1998 hearing, we are not persuaded that the proffered evidence is reasonably likely to affect the outcome of the case. That is, when considered with the current record, Dr. Olson's report is insufficient to establish the compensability of claimant's low back injury or occupational disease claim.[3] Therefore, we decline to remand the case to the ALJ for additional proceedings.[4]

ORDER

The ALJ's order dated July 8, 1998 is affirmed.

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[1] At hearing, claimant made his request based on two theories: First, the reports in the record from claimant's physicians were not responsive to the questions he asked of them regarding causation; second, the reports contained final rebuttal evidence regarding a May 8, 1998 insurer-arranged medical examination (IME) report (Exhibit 13A) submitted by SAIF. SAIF objected to claimant's request and withdrew the IME report. The ALJ, after finding that claimant had been diligent in his attempts to secure the additional reports, nevertheless denied claimant's request on the basis that he was merely seeking additional evidence to bolster his case.

[2] Apparently, an additional report from Dr. Harper is no longer at issue.

[3] Dr. Olson based his opinion that the major contributing cause of claimant's low back radiculitis was his work on two factors: First, that claimant exerienced an incident at work, and, second, that claimant had not experienced symptoms prior to the work incident. At hearing, claimant was unable to identify any incident at work. (Tr. 33, 34). Moreover, the medical record indicates that claimant had a long-standing, chronic low back condition. Although there is some evidence that something happened to worsen his low back symptoms, for which he had treated since mid-October 1997, on or about November 7, 1998, neither claimant's testimony nor the medical record is sufficient to establish compensability.

[4] Because remand is not appropriate in this case, we need not address whether the ALJ abused his discretion in declining to admit Dr. Olson's report.

In the Matter of the Compensation of
JENNIFER FRYE, Claimant
WCB Case No. C8-02074
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

On September 14, 1998, the Board acknowledged receipt of 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); *Jeanne P. Morgan*, 47 Van Natta 1062 (1995).

The first page of the agreement provides for a waiver of the "30-day" waiting period. On September 17, 1998, because claimant was not represented by an attorney, the Board requested that the parties remove the waiver language by submitting an addendum.

To date, the Board has not received an addendum. Notwithstanding this failure to respond, the statutory 30-day "cooling off" period has expired. Consequently, our prior concerns regarding the "waiver" provision have become moot. Therefore, we have proceeded with our review of the agreement.

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
DAVID E. McATEE, Claimant
WCB Case No. 97-01943
ORDER DENYING RECONSIDERATION
Schneider, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

The self-insured employer requests reconsideration of our April 2, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which upheld the employer's denial of claimant's current "combined condition." In our order, we concluded that the employer's denial was procedurally invalid.[1]

Prior to the employer's request for reconsideration, it petitioned the Court of Appeals for judicial review of our April 2, 1998 Order on Review. ORS 656.295(8). As the 30-day period within which to withdraw and reconsider our order has expired, jurisdiction of this matter currently rests with the court. ORS 656.295(8); ORS 656.298(1); *Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *SAIF v. Fisher*, 100 Or App 288 (1990).

Nevertheless, the employer asks that we exercise our authority to withdraw the appealed order in order to reconsider our decision in light of *Tracey A. Blamires*, 50 Van Natta 1793 (1998), which issued subsequent to our order.[2] *See* ORS 183.482(6); ORAP 4.35; *Glen D. Roles*, 43 Van Natta 278 (1991). The employer contends that the reasoning expressed in *Blamires* casts serious doubt on whether our decision in the present case remains valid and accurately reflects the Board's current policy.

We rarely exercise our authority to withdraw an appealed order for purposes of reconsideration. *Carole A. VanLanen*, 45 Van Natta 178 (1993). We decline to do so in the present case. Because the question posed by the employer's request is one of legal interpretation (*i.e.*, statutory construction), and because this matter is presently before the court, the parties may present their respective positions before that forum concerning the effect, if any, the holdings in *SAIF v. Belden*, 155 Or App 568 (1998), and *Blamires*, may have on this case. Such a procedure will provide the court with an opportunity to address this important legal issue regarding a carrier's claim processing obligations under the statutory scheme or, if the court considers such an action to be warranted, to remand this case to this forum for reconsideration. Consequently, we find that judicial and administrative efficiency is best served by declining the request to withdraw our order for reconsideration. *Id.*

Accordingly, the employer's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986).

IT IS SO ORDERED.

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[1] In reaching that decision, we relied on the employer's acceptance of an "acute lumbar strain (combined condition)" resulting from an injury with the present employer, superimposed on a preexisting injury with a prior employer. Based on that acceptance, we concluded that the present employer remained responsible for future compensable treatment and disability for the combined condition under ORS 656.308(1), unless claimant sustained a subsequent "new compensable injury."

[2] In *Blamires*, we disavowed prior Board cases holding that a carrier must accept a combined condition before availing itself of the pre-closure denial procedure under ORS 656.262(7)(b). We, instead, reasoned that ORS 656.262(7)(b) is applicable when the medical evidence developed subsequent to an acceptance discloses that the compensable injury either combined at the outset, or subsequently combined, with a preexisting condition.

In the Matter of the Compensation of
CHARLOTTE M. SOROS, Claimant
WCB Case Nos. 97-08397 & 97-08299
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that awarded claimant's attorney a $2,000 fee pursuant to ORS 656.382(2). Claimant's brief includes a motion to dismiss the insurer's request for Board review on the basis that the insurer failed to mail a copy of the request for review to claimant's attorney. On review, the issues are motion to dismiss and attorney fees. We deny the motion to dismiss and reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Citing OAR 438-011-0005(2),[1] claimant contends that the insurer's request for Board review should be dismissed. Claimant asserts that the insurer did not send a copy of its request for Board review to his counsel of record. According to claimant, the request for review was not properly or timely filed and must be dismissed.

The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51 (1985); *Argonaut Insurance v. King*, 63 Or App 847, 852 (1983).

Under ORS 656.005(21), a "party" means "a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer." In the present case, there is no contention that the insurer did not mail a copy of the request for review to claimant. Attorneys are not included within the statutory definition of "party." *Yekaterina Drevenchuk*, 49 Van Natta 1016 (1997). Thus, we conclude that the insurer's request for review was timely filed. *See* ORS 656.289(3); ORS 656.295(2).

Furthermore, although claimant contends that the insurer failed to provide a copy of its request for Board review to claimant's counsel of record, we find that claimant's attorney had actual notice of the insurer's request for review. The ALJ's order was dated June 19, 1998. The insurer's July 2, 1998 request for review indicates that a copy was sent to claimant's previous counsel of record, not claimant's counsel at hearing. However, on July 8, 1998, the Board acknowledged the insurer's request for review and a copy of that acknowledgment was sent to claimant's counsel of record. Thus, we find that claimant's counsel received actual notice of the insurer's appeal by receiving the Board's acknowledgment letter. Because there is no contention that claimant's counsel of record was prejudiced by not directly receiving a copy of the insurer's request for review, we find that the insurer's request for review adequately complied with OAR 438-011-0005(2). *See generally Nancy C. Prevatt-Williams*, 48 Van Natta 242 (1996) (because there was no contention that the claimant was prejudiced by not directly receiving a copy of the carrier's request for review, the Board held that the carrier's timely service by mail upon the claimant's counsel was adequate compliance with ORS 656.295(2)).

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[1] OAR 438-011-0005(2) (WCB Admin. Order No. 2-1995) provides:

"Copies of a request for Board review of an Administrative Law Judge's order shall be simultaneously mailed to all parties who appeared at the hearing and to their attorneys, if represented by an attorney."

Attorney Fees

On August 14, 1996, the insurer accepted bilateral osteoarthritis of the metacarpal joint. (Ex. 9). The acceptance was later amended to identify the condition as disabling. (Ex. 13). On October 18, 1996, a stipulation was approved whereby the insurer accepted osteoarthritis of the trapezium of the right hand and left hand tendonitis. (Ex. 14).

A May 16, 1997 Determination Order awarded temporary disability benefits and 29 percent scheduled permanent disability for loss of use or function of claimant's right forearm (wrist). (Ex. 17). Claimant's then-attorney requested reconsideration, challenging only the permanent disability award. (Ex. 21). A September 16, 1997 Order on Reconsideration awarded claimant 23 percent scheduled permanent disability for loss of use or function of the left forearm (wrist) and 40 percent scheduled permanent disability for loss of use or function of the right forearm (wrist). (Ex. 23).

On October 3, 1997, claimant's former attorney requested that the Workers' Compensation Division abate and reconsider the Order on Reconsideration to award additional temporary disability benefits. (Ex. 25). The Division declined to abate the Order on Reconsideration. (Ex. 26). Claimant's former attorney filed a request for hearing raising the issue of temporary disability benefits. (Ex. 27).

The insurer subsequently filed a request for hearing concerning the scheduled permanent disability award. On the day of hearing, the insurer withdrew its request for hearing.

The ALJ found that the issue of temporary disability benefits was not raised in claimant's request for reconsideration and that issue did not "arise out of" the Order on Reconsideration. Consequently, the ALJ held that the Hearings Division did not have jurisdiction to address the issue of temporary disability benefits.

The ALJ found that claimant's attorney was entitled to a $2,000 attorney fee under ORS 656.382(2). Finding that the insurer's request for hearing stayed payment of compensation for approximately eight months, the ALJ reasoned that it would be "entirely inappropriate" to allow the insurer to stay the payment of compensation under these circumstances without imposing some sanction.

ORS 656.382(2) provides that if a request for hearing is initiated by a carrier and the ALJ finds that the compensation awarded to a claimant should not be disallowed or reduced, the carrier shall be required to pay to claimant or claimant's attorney a reasonable attorney fee for legal representation by an attorney for the claimant at and prior to the hearing.

There are three prerequisites for an attorney fee award under ORS 656.382(2): (1) a carrier must initiate a hearing request to obtain a disallowance or reduction in a claimant's compensation award; (2) the claimant's attorney must perform legal services in defense of the compensation award; and (3) the ALJ must find on the merits that the compensation award should not be disallowed or reduced. *Deaton v. Hunt-Elder*, 145 Or App 110, 114-115 (1996); *Strazi v. SAIF*, 109 Or App 105, 107-108 (1991); *Julian Salazar*, 47 Van Natta 450 (1995).

The dispute in this case is over whether the third prerequisite has been satisfied, *i.e.*, whether the ALJ found on the merits that claimant's scheduled permanent disability award should not be disallowed or reduced. We agree with the insurer that the ALJ's order was not a decision on the merits regarding the scheduled permanent disability award. Consequently, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated June 19, 1998 is reversed in part. That portion that awarded an attorney fee award under ORS 656.382(2) is reversed. Claimant's motion to dismiss the insurer's request for review is denied.

In the Matter of the Compensation of
MELVIN R. TEFFT, Claimant
Own Motion No. 98-0368M
OWN MOTION ORDER OF ABATEMENT
Pozzi, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 24, 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 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
JEFFREY V. COLLADO, Claimant
WCB Case No. 98-01222
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that decreased claimant's unscheduled permanent disability award for a low back injury from 26 percent (83.2 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found that claimant's condition apparently exacerbated in November 1997, subsequent to the administrative closure of the claim. (Ex. 14A). Furthermore, the ALJ found that the medical arbiter, Dr. Gritzka, did not provide a persuasive evaluation of claimant's permanent impairment due to his compensable injury because Dr. Gritzka had found that claimant's condition was not medically stationary at the time of his examination. (Ex. 19-5). The ALJ based his reasoning on *Phyllis G. Nease*, 49 Van Natta 195, *on recon* 49 Van Natta 301, *on recon* 49 Van Natta 494 (1997), and *Georgina F. Luby*, 49 Van Natta 1828 (1997). We agree.

Claimant has the burden of proving the extent of his permanent disability. ORS 656.266. On review, claimant argues that the ALJ erred in relying on *Nease* and *Luby* because, unlike the medical arbiters in those cases, the medical arbiter here only suspected that claimant might not be medically stationary. We disagree with claimant's interpretation of Dr. Gritzka's opinion. Dr. Gritzka explicitly stated that, in his opinion, claimant "has not reached maximum medical improvement" and recommended a short course of physical therapy, after which Dr. Gritzka thought claimant would recover without impairment. (Ex. 19-5). Thus, Dr. Gritzka's opinion was that claimant was not medically stationary when he examined him. Therefore, our decisions in *Nease* and *Luby* are directly on point. Accordingly, the ALJ did not err in applying those decisions to find the medical arbiter's opinion unpersuasive as a measurement of permanent impairment due to the work injury.

Having found the findings of the medical arbiter unpersuasive, the only other evidence that may be considered in evaluating claimant's permanent impairment are the findings of the attending physician, Dr. Gardener. *See* ORS 656.245(3)(b)(3); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). We agree with the ALJ that Dr. Gardener makes no impairment findings upon which to base an award of permanent disability.

Claimant apparently failed to appear for an appointment with Dr. Gardner scheduled for August 21, 1997. (Ex. 7). On August 26, 1997, Dr. Gardener indicated that claimant's impairment was undetermined and claimant's next appointment was scheduled for September 8, 1997. (Ex. 9). Claimant apparently failed to appear for that appointment as well, and his claim was subsequently administratively closed by a Notice of Closure dated October 6, 1997.[1] (Exs. 10, 13, 14).

On November 6, 1997, claimant returned to Dr. Gardner and complained of increased back pain after heavy lifting at work. (Ex. 14A). Dr. Gardner diagnosed recurrent back strain with symptoms exacerbated by heavy lifting. (*Id.*). In addition, Dr. Gardner signed a November 5, 1997 "Fitness for Duty Report," indicating that claimant was restricted to "indefinite, permanent modified duty" consisting of no lifting over 70 pounds. (Ex. 15-2). Claimant argues that this lifting restriction establishes permanent impairment. However, claimant cites to no standard that would provide an impairment rating for such a restriction, and we can find none.

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[1] Both SAIF and claimant initially requested a hearing regarding the January 29, 1998 Order on Reconsideration. Claimant's hearing request raised, among other issues, the issue of premature closure. However, at hearing, claimant withdrew his hearing request, and the hearing proceeded regarding the issues raised by SAIF's hearing request. (Tr. 4-5).

In this regard, ORS 656.726(3)(f) provides that the Director is charged with the duty to provide standards for evaluation of disabilities. Moreover, the criteria for rating unscheduled permanent disability "shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job." ORS 656.726(3)(f)(A). OAR 436-035-0270(2) provides that "[i]f there is no measurable impairment under these rules, no award of unscheduled permanent partial disability shall be allowed." OAR 436-035-0320 through 436-035-0450 provide the rules for determining impairment rated as unscheduled disability. OAR 436-035-0320(1) and (2).

Restrictions on lifting are not rated as impairment under the standards but, instead, are considered under the adaptability factor. OAR 436-035-0310. The adaptability factor is multiplied by the other nonimpairment factors (*i.e.*, the age and education factors) and that value is then added to the impairment value to determine the award of unscheduled permanent disability. ORS 656.726(3)(f)(A); OAR 436-035-0280. Thus, while lifting restrictions are considered in determining an unscheduled permanent disability award, they are not rated as impairment under the standards. Because Dr. Gardner's only limitation involved a lifting restriction, claimant has established no measurable impairment on this record and, therefore, is not entitled to any award for unscheduled permanent disability. OAR 436-035-0270(2).

ORDER

The ALJ's order dated April 28, 1998 is affirmed.

October 22, 1998 Cite as 50 Van Natta 2076 (1998)

In the Matter of the Compensation of
ALEX BARRIOS, Claimant
WCB Case No. C8-02157
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Bock and Biehl.

On October 1, 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 October 14, 1998, we received a letter from claimant's current attorney of record requesting that the October 1, 1998 order of approval be abated. Specifically, claimant seeks an opportunity to clarify "any misunderstandings regarding the nature and terms" of the settlement which may have occurred during his prior representation by another attorney.

We deny the motion. In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2).

Here, the CDA was approved and mailed on October 1, 1998. We received claimant's current attorney's letter requesting abatement of the CDA on October 14, 1998, 13 days after the CDA was approved. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. *OAR 438-009-0035(1),(2); Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we lack either statutory or regulatory authority to alter the previously approved CDA. Thus, we decline to abate our order of approval.

IT IS SO ORDERED.

In the Matter of the Compensation of
FILIBERTO GARIBAY, Claimant
WCB Case No. 96-03130
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of claimant's occupational disease claim for a bilateral upper extremity condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's March 15, 1996 denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome, as well as the insurer's amended denial of April 24, 1997, which included bilateral wrist tendonitis, bilateral hand/wrist sprain/strain, and bilateral hand/wrist syndrome as denied conditions. In upholding the insurer's denials, the ALJ found unpersuasive the medical opinions of Drs. Collada, Verzosa, and Bhasin, who offered medical reports in support of claimant's occupational disease claim.

On review, one of claimant's contentions is that the ALJ failed to address the compensability of the denied conditions apart from bilateral carpal tunnel syndrome.[1] We disagree.

The nature of claimant's bilateral hand/wrist complaints has been difficult to determine.[2] This has resulted in a number of diagnoses for claimant's bilateral upper extremity symptoms. (Exs. 18, 22, 24, 25, 32). As previously noted, the ALJ upheld the amended denial which included the conditions for which claimant now seeks a specific compensability determination. Thus, the ALJ did address the compensability of all the denied conditions.

Moreover, it appears from Dr. Collada's medical reports that claimant's primary bilateral upper extremity condition is carpal tunnel syndrome. (Exs. 53, 60). We agree with the ALJ's reasoning and conclusions regarding the compensability of this condition. In addition, to the extent that claimant has bilateral hand/wrist conditions apart from carpal tunnel, the same deficiencies in claimant's medical evidence identified by the ALJ apply equally to those conditions as they do to the carpal tunnel condition. In other words, regardless of the diagnostic labels attached to claimant's bilateral hand/wrist condition, we agree with the ALJ's reasoning that claimant has failed to sustain his burden of proving a compensable occupational disease claim. Therefore, we find that the ALJ correctly upheld the insurer's denials.

ORDER

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

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[1] We find that the ALJ's order adequately addresses claimant's other contentions.

[2] In fact, several physicians (Drs. Nolan, Button and Stringham) have questioned whether claimant has an organic physical condition. (Exs. 46, 48, 52).

In the Matter of the Compensation of
BARBARA J. HUEY, Claimant
WCB Case No. 98-01170
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's low back and left lower quadrant abdominal strain. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. We do not adopt the ALJ's ultimate findings of fact.

In the last paragraph beginning on page 1, we change the word "expensive" in the second sentence to read "extensive." In the third full paragraph on page 2, we change the first sentence to read: "On December 5, 1997, claimant sought treatment from a nurse practitioner for low back and left flank pain. (Ex. 8a)." In the last paragraph beginning on page 3, we change the date in the fourth sentence to "1977."

In the first full paragraph on page 4, we change the second sentence to read: "The history noted is severe, acute low back and left flank pain since approximately 5:30 a.m. on December 5, 1997. (Ex. 8a)." In the same paragraph, we change the date of "December 30, 1998" in the fourth sentence to read "December 30, 1997." In the same paragraph, we change the fifth sentence to read: "Claimant's low back injury and surgery 20 years ago was noted, with claimant reporting no further symptoms to her low back area until after the October 8, 1997 injury." In the last paragraph on page 5, we delete the fifth sentence.

In the first full paragraph on page 6, we replace the first sentence with the following:

> "Although claimant has preexisting degenerative disc disease in her lumbar spine, we find no medical evidence that the work injury has *combined* with the preexisting condition to cause or prolong disability or a need for treatment. *See Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997); *Leon M. Haley*, 47 Van Natta 2056, *on recon* 47 Van Natta 2206 (1995). Therefore, ORS 656.005(7)(a)(B) does not apply. Claimant need only establish that the work injury was a material contributing cause of her low back condition."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 20, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,400, payable by the self-insured employer.

In the Matter of the Compensation of
TIMOTHY W. STONE, Claimant
WCB Case No. 97-06478
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the SAIF Corporation's *de facto* denial of claimant's right foot plantar fasciitis and bilateral wrist osteoarthritis; and (2) declined to assess a penalty for SAIF's allegedly unreasonable failure to timely accept or deny those conditions. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has an accepted claim for a left tibia and fibula fracture sustained in a 1991 left leg injury with the employer. Following that injury, claimant experienced a significant loss of use of the left leg and a severely altered gait, but he remained quite active with the use of a cane or crutches, by favoring his left leg and putting considerable pressure on his right foot. In October 1996, claimant sought treatment for bilateral wrist pain and right heel pain dating back to 1995. Radiographs of the wrists demonstrated bilateral radiocarpal arthritic changes. Radiographs of the lower extremities demonstrated a "spur" in the os calcis area of the right heel. Claimant's wrist symptoms were attributed to bilateral ganglions and radiocarpal arthritis, and his right heel pain was diagnosed as plantar fasciitis.

Dr. Webb, M.D., provided conservative treatment. Dr. Donahoo, orthopedic surgeon, evaluated claimant's wrist and foot complaints for SAIF on January 30, 1997. Dr. Bonafede, rheumatologist, evaluated claimant's wrist complaints for SAIF on April 9, 1997.

By letter dated March 27, 1997, claimant requested that SAIF amend its Notice of Acceptance to include claimant's right foot plantar fasciitis and bilateral radiocarpal arthritis. (Ex. 8). When SAIF did not issue a formal, written acceptance or denial of these conditions, claimant requested a hearing on June 26, 1997, and again on July 28, 1997.

CONCLUSIONS OF LAW AND OPINION

Preliminary Procedural Matter

The Board's December 3, 1997 Interim Order of Dismissal issued in this matter is hereby incorporated into this order by reference.

Compensability

Claimant contends that the ALJ erred in concluding that claimant's bilateral wrist osteoarthritis and right plantar fasciitis are not compensable consequences of his accepted left leg injury. We adopt and affirm the ALJ's conclusion that the bilateral wrist condition is not compensable. However, we conclude that the record establishes compensability of the right foot plantar fasciitis.

To establish compensability of the right foot plantar fasciitis, claimant must prove that the accepted left leg injury is the major contributing cause of this consequential condition. ORS 656.005(7)(a)(A). 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).

The treating physician, Dr. Webb, opined that claimant's 1991 injury was the major contributing cause of claimant's right plantar fasciitis. Dr. Webb explained that for years claimant has been unable to bear weight evenly on both lower extremities, has dramatically favored the left lower extremity, and has applied nearly full weight-bearing force through the right lower extremity which directly relates to the development of plantar fasciitis of the right foot. (Exs. 3 and 4).

SAIF's medical examiner, Dr. Donahoo, opined that claimant's fasciitis was of the "garden variety" and not related to the left leg condition. Dr. Donahoo reasoned that individuals with a leg injury reduce their overall activity and, therefore, actually place no more and sometimes less pressure and weight on the uninjured foot then they did in their normal activity prior to the injury. Dr. Donahoo explained that this was well known in the amputee literature and gait studies of individuals with an antalgic gait as a result of arthritis and polio myelitis. (Ex. 5).

In response to Dr. Donahoo's opinion, Dr. Webb explained that claimant did not fit into the category of "relative inactivity." Dr. Webb based this conclusion on his evaluation of claimant on numerous occasions dating back to June of 1992. Dr. Webb noted that claimant had pushed himself more than the average individual with similar limitations, and had tried to maintain activity at the highest possible level. (Ex. 6).

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, we find no persuasive reason not to defer to Dr. Webb. In particular, his long-term treatment of claimant places Dr. Webb in the best position to evaluate the post-injury stress on claimant's right heel. Furthermore, Dr. Donahoo's opinion is less persuasive because it is based on general studies that are not particular to claimant. *See Sherman v. Western Employer's Insurance, 87 Or App 602 (1987); Charles Moody*, 48 Van Natta 2085 (1996). Finally, we disagree with the ALJ's reasoning that Dr. Webb's opinion must be discounted because it is inconsistent with radiographic evidence of bilateral heel spurs. We instead conclude that claimant's right heel spur is a separate condition that is unrelated to his plantar fasciitis.

Accordingly, we defer to Dr. Webb and conclude that claimant has established compensability of his right plantar fasciitis. Consequently, claimant is entitled to an assessed attorney fee for prevailing over SAIF's denial of this condition. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time expended in establishing compensability of the plantar fasciitis condition (as represented by the hearing record and claimant's brief on review), the complexity of this issue, the risk that claimant's counsel might go uncompensated, and the value of the interest involved.

Penalties

Claimant contends that he is entitled to a penalty for SAIF's failure to accept or deny his bilateral wrist condition and right plantar fasciitis. The ALJ concluded that penalties and related fees could not be assessed because these conditions were not compensable. As we have affirmed the ALJ's decision that claimant has not established a compensable claim for his bilateral wrist condition, we also agree with the ALJ's conclusion that there is no basis for assessing a penalty or related fee in regard to this condition.

However, in light of our conclusion that the right plantar fasciitis is compensable, a penalty can be assessed if SAIF's claims processing was unreasonable. We conclude that it was. The record contains a March 27, 1997 letter to SAIF in which claimant's counsel requests that it amend its notice of acceptance to include the right plantar fasciitis. This letter triggered SAIF's duty to issue a formal, written acceptance or denial of that condition within 30 days. *See* ORS 656.262(6)(d).[1] SAIF's failure to do that was unreasonable and warrants the assessment of a maximum 25 percent penalty under ORS 656.262(11)(a).

ORDER

The ALJ's order dated September 18, 1997 is affirmed in part and reversed in part. That portion of the order that upheld the SAIF Corporation's denial of claimant's right plantar fasciitis is reversed, and the claim for that condition is remanded to SAIF for further processing according to law. That

[1] Even if SAIF had 90 days to respond to claimant's request under ORS 656.262(7)(a), SAIF also did not take appropriate action within that time period. Consequently, whether analyzed under ORS 656.262(6)(d) or 656.262(7)(a), SAIF's conduct was unreasonable.

portion of the ALJ's order that declined to assess a penalty for SAIF's *de facto* denial of claimant's right plantar fasciitis is also reversed. Claimant is awarded a 25 percent penalty under ORS 656.262(11), to be based on the amounts then due at hearing as a result of this order, to be shared equally by claimant and his attorney. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant is awarded an assessed fee of $4,000, to be paid by SAIF.

In the Matter of the Compensation of
MARY L. LONG, Claimant
Own Motion No. 97-0516M
OWN MOTION ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her compensable lumbar strain. Claimant's aggravation rights on that claim expired on November 4, 1991.

On October 28, 1997, SAIF denied the compensability of claimant's current herniated disc at L5-S1 and need for laminotomy and discectomy at L5-S1. Claimant requested a hearing. (WCB Case No. 97-09228). We postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated May 13, 1998, Administrative Law Judge (ALJ) Stephen Brown upheld SAIF's October 28, 1997 denial. On June 16, 1998, we issued our Own Motion Order, which declined to reopen claimant's claim based on ALJ Brown's May 13, 1998 order. We took that action because we were unaware that ALJ Brown's order had been appealed.

However, claimant did timely request Board review of ALJ Brown's order and requested reconsideration of our June 16, 1998 Own Motion Order. On July 1, 1998, we abated our Own Motion order pending the issuance of the Board's Order on Review.

In an order issued on today's date, we affirmed ALJ Brown's order. Thus, the current condition and ensuing medical treatment for which claimant requests own motion relief, remains in denied status. As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*

Accordingly, on reconsideration, we adhere to and republish our June 16, 1998 order, as supplemented herein. 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
MARY L. LONG, Claimant
WCB Case No. 97-09228
ORDER ON REVIEW
Black, Chapman, 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) Stephen Brown's order that upheld the SAIF Corporation's partial denial of her current L5-S1 herniated disc. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

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

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[1] The ALJ found, and we agree, that claimant has not proven that her 1986 low back injury was a material contributing cause of her current L5-S1 herniated disc. Because claimant has not sustained her burden under a material contributing cause standard, she has likewise failed to prove that her accepted 1996 low back sprain was the major contributing cause of her resultant L5-S1 herniated disc condition. *See* ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied).

In the Matter of the Compensation of
THOMAS K. BOWDISH, Claimant
Own Motion No. 98-0377M
OWN MOTION ORDER RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 21, 1998 Own Motion Order in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that: (1) he required surgery or hospitalization; and (2) he was in the work force at the time of disability. With his request for reconsideration, claimant submitted additional medical documentation regarding his need for surgery.

On October 5, 1998, we abated our September 21, 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 review.

Claimant relies on a July 2, 1998 insurer-arranged medical examination (IME) report from Dr. Mayhall, who opined that claimant is "probably a candidate for valgus osteotomy (reconstructive surgery)." Claimant further contends that Dr. Noall concurred with the IME report.

However, Dr. Mayhall's opinion regarding treatment for claimant's compensable left knee condition was not limited to surgery. Indeed, Dr. Mayhall reported that conservative treatment was first indicated; *e.g.* physical therapy and corticosteroids. Dr. Mayhall further indicated that more diagnostic testing needed to be performed before attempting a surgical intervention. Finally, Dr. Mayhall referred claimant back to Dr. Noall for further evaluation and suggestions for treatment.

When reviewed in context within the entire report, we do not consider Dr. Mayhall's comment regarding claimant "probably" being a candidate for surgery, to be persuasive evidence regarding a need for surgery. Further, Dr. Noall's "concurrence" with Dr. Mayhall's opinion was limited to whether claimant's current condition was compensably related to his accepted left knee medial meniscus tear and left knee degenerative joint disease.

Inasmuch as we have found Dr. Mayhall's opinion unpersuasive and there being no other evidence in the record that surgery has been recommended, we conclude the record fails to demonstrate that claimant presently requires surgery or hospitalization. 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, on reconsideration, as supplemented herein, we adhere to and republish our September 21, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] Should circumstances change, and conservative measures prove to be unsuccessful, surgery and/or inpatient hospitalization may eventually be required. If and when that situation arises, claimant may again request reopening of his claim for the payment of temporary disability. *See* ORS 656.278(1).

In the Matter of the Compensation of
FRANK M. PUTNAM, Claimant
WCB Case No. C8-02141
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ray Myers (Saif), Defense Attorney

Reviewed by Board Members Bock and Haynes.

On September 23, 1998, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b); *Jeanne P. Morgan*, 47 Van Natta 1062 (1995).

The first page of the agreement has been amended and initialed by claimant to provide for a waiver of the "30-day" waiting period. Because claimant is unrepresented, the Board is without statutory authority to waive the 30-day statutory period and has thus, allowed the "cooling-off period" to expire before considering the agreement for approval.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD C. ALEXANDER, Claimant
WCB Case No. 98-01695
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) found that a previously unappealed denial did not preclude claimant from litigating his current right knee condition; and (2) set aside the insurer's denial of claimant's right knee condition. On review, the issue is whether the claim is precluded and, if not, compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In September 1997, the insurer issued a denial of "bilateral varus knee posture (mild bull-leg) with mild associated tibial rotation, dynamic patellofemoral off-tracking with crepitance." Claimant did not appeal the denial.

In January 1998, claimant again sought treatment for right knee pain. Based on an MRI, claimant was diagnosed with a tear in the medial meniscus. During arthroscopic surgery, however, a thickened medial plica was revealed. The insurer then denied the medial plica syndrome condition.

The ALJ found that the insurer's September 1997 denial did not preclude claimant from litigating the medial plica syndrome condition because the condition was not diagnosed until after the denial issued. Relying on *Margaret R. Jones*, 45 Van Natta 1249 (1993), the insurer contends that, because the medial plica syndrome condition was causing claimant's symptoms before and after the September 1997 denial, the denial precludes claimant from litigating the medial plica syndrome condition. As discussed below, we conclude that even if the medical plica condition was the cause of claimant's symptoms throughout this period, nevertheless claimant is not precluded from litigating the compensibility of his condition as it currently exists.

An uncontested denial bars future litigation of the denied condition unless the condition has changed and the claimant presents new evidence to support the claim that could not have been presented earlier. *Popoff v. J. J. Newberrys*, 117 Or App 242 (1992); *Liberty Northwest Ins. Corp. v. Bird*, 99 Or App 560, 563-64 (1989), *rev den* 309 Or 645 (1990). A worsening of the denied condition is considered a "changed" condition. *See Kepford v. Weyerhaeuser*, 77 Or App 363, 365, *rev den* 300 Or 722 (1986).

Here, according to claimant's treating orthopedic surgeon, Dr. Walton, before September 1997, claimant was probably suffering from medial plica syndrome. (Ex. 21-10). Dr. Walton also indicated that claimant's increased symptoms between September 1997 and January 1998 would be due to additional trauma from work activities. (*Id.* at 14). Dr. Walton subsequently indicated that claimant's symptoms were worse in January 1998 and there was a "substantial change" in claimant's condition between September 1997 and January 1998. (Ex. 23).

Based on such evidence, we find that claimant proved that his condition worsened after the September 1997 denial, thereby constituting a "changed" condition. Thus, the uncontested September 1997 denial does not preclude claimant from litigating his current condition.

In this regard, we find *Margaret R. Jones* distinguishable from this case. In *Jones*, the Board found that, although the physicians used different terminology, the claimant was treating for the same condition before and after the uncontested denial. The Board concluded that, because the "claimant failed to timely appeal [the carrier's] denial of her claim for the same condition and [the medical evidence] fails to specify that [the] claimant's 'post-denial' work activities changed her condition," it

upheld the second denial. 45 Van Natta at 1250. Here, as discussed above, the medical evidence shows that claimant's condition did change in that it worsened after the September 1997 denial. On this basis, *Jones* is distinguishable.

Finally, the insurer seems to assert that its denial should be partially upheld because there is insufficient evidence that claimant's work after the September 1997 denial was the major contributing cause of the medial plica syndrome condition. Whether or not claimant is under this burden of proof, we find that he carried it. According to Dr. Walton, claimant's work activities were the major contributing cause of the medial plica syndrome condition and claimant's increased symptoms between September 1997 and January 1998 would be due to additional trauma from work activities. (Exs. 18, 19, 21-14). Based on this record, we find that claimant proved that work activities were the major contributing cause of the medial plica syndrome condition and its worsening after September 1997.

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

ORDER

The ALJ's order dated July 2, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

October 22, 1998 Cite as 50 Van Natta 2086 (1998)

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 OF ABATEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

On September 24, 1998, we issued an Order on Review that upheld the self-insured employer's denial of claimant's new occupational disease claim for a low back condition. Asserting that our decision fails to apply the proper legal standard, claimant seeks reconsideration.

In order to further consider this matter, we withdraw our September 24, 1998 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD A. GLENN, Claimant
WCB Case No. 96-01649
ORDER ON REMAND
Scott McNutt, Sr., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

This matter is on remand from the Court of Appeals. *Roseburg Forest Products v. Glenn*, 155 Or App 318 (1998). The court has reversed our prior order that adopted an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's injury claim for low back strain and L4-5 disc conditions. The court held that we erred: (1) in rejecting a medical opinion on the basis that it was "prepared in anticipation of litigation;" and (2) in discounting another opinion for an incomplete or inaccurate history when a third opinion (on which we relied) appeared to be based on the same history. Accordingly, the court has remanded for reconsideration of the medical record.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant began working in the employer's lumber mill in November 1992. In April 1995, he experienced low back pain and sought treatment from Dr. Brazer. Claimant reported a history of "problems in the past," and attributed his then-current symptoms to moving a piece of wood at work in March 1995. (Ex. 4). He treated conservatively, lost no work time, and his symptoms resolved.

On November 29, 1995, claimant lifted and tossed a piece of panelboard at work and felt the immediate onset of pain in his low back. He reported the injury to his supervisor and sought treatment after his shift. Dr. Brazer diagnosed an acute low back strain and took claimant off work on December 15, 1995, after physical therapy was unavailing.

A December 26, 1995 MRI revealed a moderate-sized disc protrusion at L4-5, a bulge at the "5-1" level, and degenerative disease at the lower three disc levels. (Ex. 13).

Dr. Keizer became claimant's treating physician in January 1996. The employer denied claimant's injury claim in February 1996. Claimant requested a hearing.

Based on the record as a whole, but discounting Dr. Keizer's opinion because he was unaware of claimant's prior low back pain, the ALJ concluded that the November 29, 1995 strain injury and L4-5 disc condition were compensable. On review, we adopted and affirmed the ALJ's order.

The Court of Appeals reversed our order, reasoning that we erred in weighing the medical evidence. First, the court held that we improperly rejected Dr. Farris' March 1, 1996 "concurrence letter," (Ex. 23), on the basis that it was prepared solely for litigation purposes. In reaching this conclusion, the court stated that the persuasiveness of a medical opinion depends not on the opinion's form, but on the completeness and thoroughness of its factual basis and the force of its reasoning.

Second, the court held that we erred in relying on Dr. Davis' opinion because it suffered from the same defect--an incomplete or inaccurate history--as did Dr. Keizer's rejected opinion.[1] Consequently, the court remanded for reconsideration of the medical evidence.

On reconsideration, we address the strain and disc claims individually, and re-evaluate the medical evidence as follows.

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[1] *See ante.*

Low Back Strain

Drs. Keizer, Davis, Farris,[2] and Brazer (implicitly) provide the medical evidence addressing causation. As the court explained, the former two opinions lacked complete and accurate factual bases: Dr. Keizer was unaware of claimant's prior low back pain; Dr. Davis did not know unaware that claimant had told Dr. Brazer that his spring 1995 back problems were work related. Since Dr. Keizer's and Dr. Davis' opinions are based on inaccurate or incomplete histories, we decline to rely on them. *See Somers v. SAIF*, 77 Or App 259 (1986).

Dr. Farris, neurologist, examined claimant on February 3, 1996, reviewed his history, and noted x-ray and MRI findings indicating that claimant had protruding discs at L4-5 and L5-S1 and degenerative disc disease at the lower three disc levels. (Ex. 21-2). Dr. Farris had a complete and accurate history regarding claimant's prior low back symptoms and treatment, including his early 1995 "pulled back," prior "sore muscles," and the November 29, 1995 onset of pain at work. (Ex. 21-1-2; *see* Exs. 4, 5, 6).

Dr. Farris' first "Impression" was "lumbosacral strain/sprain syndrome dated to November 29, 1995." (Ex. 21-6). But, based on her review of the medical record, Dr. Farris opined that insufficient objective findings supported Dr. Brazer's acute lumbosacral strain diagnosis. She opined that the diagnosis was really only an inference based on historical or subjective complaints. In reaching this conclusion, Dr. Farris noted that the "objective" section of Dr. Brazer's November 29, 1995 report "appeared to be essentially normal, with the back noted to be supple, the claimant retaining full ranges of motion, the deep tendon reflexes at the knee reportedly strong and equal, and heel and toe walking reportedly 'OK.'" (Ex. 23-2; *see* Ex. 6-1).

We agree that Dr. Brazer did not record objective findings on November 29, 1995. But, on December 9, 1995, Dr. Brazer *did* find and report "a lot of lumbosacral muscle tightness and flattening of the lumbar lordotic curve." (Ex. 6-2). These findings are observable and verifiable, and therefore objective. *See Geoffrey R. Lewis*, 50 Van Natta 1352, 1352 (1998). They support Dr. Brazer's acute lumbosacral strain diagnosis.

We also note that claimant was asymptomatic at the time of the November 1995 injury. No medical evidence suggests that his preexisting degeneration caused or contributed to the November 29, 1995 strain symptoms. (*See e.g.*, Ex. 23-3-4). With this in mind, and based on Dr. Brazer's findings and diagnosis, Dr. Farris' November 29, 1995 lumbosacral strain "impression," as well as claimant's credible testimony,[3] we conclude that claimant has carried his burden of proving that his November 29, 1995 work injury was a material cause of his subsequent lumbar strain condition. *See* ORS 656.005(7)(a). *Beverly Enterprises v. Michl*, 150 Or App 357 (1997) (Absent evidence of a preexisting condition, standard of proof is material cause).

L4-5 Disc Condition

Dr. Keizer became claimant's attending physician in January 1996. He suspected that an L4-5 disc problem caused claimant's need for treatment. But Dr. Keizer's opinion is not persuasive because his history was incomplete.

Dr. Farris examined claimant on February 3, 1996 and reviewed his history. She explained why claimant's L4-5 disc findings were *not* clinically significant based on the tests performed and not performed, and concluded that the November 1995 injury did not affect claimant's preexisting degeneration generally or his L4-5 disc in particular. (Ex. 23, *see* Ex. 21).

As we have explained, Dr. Farris' opinion about claimant's *strain* is not persuasive because she mistakenly believed that claimant did not have objective findings supporting the strain diagnosis. Dr. Farris' opinion about claimant's *disc*, on the other hand, *is* based on an accurate and complete history. (*See id.*) Her reasoning concerning the disc condition is also logical, consistent, and thorough.

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[2] Dr. Gritzka, orthopedist, agreed with Dr. Farris' February 3, 1996 report, but he did not comment on her subsequent "concurrence letter."

[3] We adopt the ALJ's positive demeanor-based credibility finding. Opinion and Order, p. 2.

Accordingly, we find Dr. Farris' opinion persuasive regarding the claim for an L4-5 disc condition and we rely on it. Based on that opinion, we conclude that claimant has not proven that the claimed November 1995 incident at work caused his subsequently diagnosed disc condition. Consequently, the L4-5 disc claim must fail.

Finally, claimant is entitled to an attorney fee for his counsel's services before every prior forum because he has finally prevailed before the Board after remand from the court--regarding the strain condition. *See* ORS 656.388(1). At hearing, the ALJ awarded an assessed fee of $3,000 for services at hearing regarding the strain and disc claims. On review, we awarded a $1,000 assessed attorney fee for services on review regarding both claims. Claimant's counsel also provided services before the Court of Appeals concerning both claims. Because claimant has finally prevailed only on the strain claim, his counsel is entitled to an attorney fee award for services regarding that issue performed at the hearing, Board, and court levels.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services related to the lumbar strain claim at hearing, on review, and before the court, is $4,000 payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the strain issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. No fee is awarded for services related to the L4-5 disc claim.

Accordingly, on reconsideration, the ALJ's order dated December 18, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim of an L4-5 disc condition is reversed. That portion of the denial is reinstated and upheld. In lieu of the ALJ's and our prior attorney fee awards, claimant is awarded a $4,000 carrier-paid attorney fee for services related to the lumbar strain claim at hearing, on review, and before the court. The remainder of the ALJ's order is affirmed. In other words, that portion of the employer's denial that pertains to a lumbar strain is set aside and the lumbar strain claim is remanded to the employer for processing according to law.

IT IS SO ORDERED.

October 26, 1998 Cite as 50 Van Natta 2089 (1998)

In the Matter of the Compensation of
VASILY LEVKIV, Claimant
WCB Case Nos. 97-07674 & 97-06368
ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

On September 24, 1998, we affirmed Administrative Law Judge (ALJ) Lipton's order that: (1) set aside the self-insured employer's denial of claimant's claim for his right knee condition; (2) assessed a penalty and attorney fee for the employer's allegedly unreasonable denial; and (3) upheld the employer's denial of claimant's aggravation claim for his current right shoulder condition. Announcing that the parties are in the midst of settlement negotiations, the employer seeks abatement of our decision.

Based on the representations contained in the employer's announcement, we withdraw our September 24, 1998 order. In the event that the parties resolve their dispute, they should submit their proposed settlement for our consideration. In the meantime, the parties are requested to keep us fully apprised of any future developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
GEORGE JONES, Claimant
WCB Case No. C8-02349
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Neil W. Jones, Defense Attorney

Reviewed by Board Member Biehl and Bock.

On October 16, 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 summary page of the CDA provides for a full release by claimant of his rights to permanent partial disability (PPD) benefits on the claim. On page 2, paragraph 8, however, the agreement provides that: "The total amount of permanent disability benefits awarded on the claim is 30 % (equal to 57.6 degrees) scheduled permanent partial disability, *which will be paid as a part of this settlement.*" (Emphasis added). Page 3, paragraph number 18, has been altered and initialed by the parties to provide that "the parties acknowledge and agree that claimant has already been paid by SAFECO his PPD award in full." The total consideration for the CDA provided on the summary page and page 1 of the CDA has also been altered by the parties. As revised, the CDA provides for a total consideration of $28,679.88.

It is apparent that the CDA was originally drafted to include the amount of the unpaid PPD award as part of the consideration for the CDA. At some point prior to submitting the CDA to the Board, however, the carrier paid the PPD award in full. The parties then attempted to alter the CDA to deduct the amount of the unpaid PPD award from the consideration. Although the parties revised paragraph 18, on page 3 to provide that the PPD award had been fully paid and had revised the total consideration to deduct the amount of the PPD award, they neglected to similarly revise paragraph 8 on page 1, which still provides that the PPD award will be paid as part of the consideration for the CDA.

Under such circumstances, we conclude that paragraph 8 on page 1 was erroneously left intact. Consequently, we interpret the CDA as providing that the total consideration for the agreement is $28,679.88. This consideration does not include the PPD award which has been fully paid by the carrier prior to submission of the CDA to the Board.

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
JAMES M. KING, Claimant
Own Motion No. 98-0171M
OWN MOTION ORDER
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable 1977 myocardial infarction, coronary bypass, and coronary artery disease. Claimant's aggravation rights on that claim expired on August 9, 1983.

On April 9, 1998, SAIF denied the current care, treatment and possible surgery for claimant's current coronary artery disease and peripheral vascular disease condition. Claimant requested a hearing. (WCB Case No. 98-03312). We consolidated the own motion matter with the pending action before the Hearings Division as SAIF had raised work force issues. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

By Opinion and Order dated August 13, 1998, ALJ Mills upheld SAIF's April 9, 1998 denial insofar as it denied the compensability of claimant's current peripheral vascular disease. Finding that SAIF had agreed that claimant's current coronary artery disease "remained accepted," ALJ Mills concluded that claimant's November 1997 treatment, in part, was due to his "compensable heart claim." Further, ALJ Mills found that claimant had returned to the work force in the fall of 1997 and continued to work until his condition worsened requiring surgery and hospitalization. That order was not appealed.

In his own motion recommendation, ALJ Mills found that while claimant was initially hospitalized for treatment for a noncompensable condition, the "majority of his ultimate treatment in the hospital was related to his accepted coronary artery disease condition." Having found that claimant was in the work force prior to his hospitalization and that the surgery claimant underwent on November 13, 1997 was for his compensable heart condition, ALJ Mills recommended that claimant's claim be reopened for the provision of temporary disability compensation.

In response to ALJ Mills' Own Motion Recommendation, SAIF agrees that a portion of claimant's surgery and hospitalization was due to the compensable coronary artery disease. SAIF further acknowledges that claimant reentered the work force prior to his surgery in November 1997.

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

On November 13, 1997, claimant underwent an angiogram of his heart and, on November 19, 1997, underwent an angioplasty procedure for his coronary artery disease. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. Based on the ALJ's uncontested findings, we further find that claimant was in the work force at the time of his disability.

Accordingly, we authorize the reopening of claimant's 1977 injury claim to provide temporary disability compensation beginning November 13, 1997, 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.

In the Matter of the Compensation of
FRANK SICA, Claimant
WCB Case No. 97-09659
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of his claim for a right thumb, left ring finger, back and jaw injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a construction worker, began working for the employer in August 1997. (Ex. 17-3, Tr. 14). He was a member of a union, Plumbers and Steam Fitters Local 342 out of California. (Tr. 15). The employer provided a bus service from the work area to a parking lot, which was approximately one mile away. (Tr. 16). Claimant's normal work hours were 6:00 a.m. to 4:30 p.m. and he testified that the workers were considered to be on the job until leaving the parking lot at the end of the day, at approximately 4:30 p.m. (Tr. 18, 22).

For security purposes, the employer gives each employee a brass token when they arrive and they are required to return the brass token when they leave the jobsite. (Tr. 20, 21). On October 8, 1997, claimant was talking to Mr. Funches, a co-worker, while they were waiting in the "brass" line before getting on the bus. (Tr. 34, 134). Mr. Funches pointed out the local union's business agent and claimant commented that he did not know the local union had a business agent for this job. (Tr. 35, 134-35). Funches replied that claimant must not get to the union hall too often. (Tr. 35, 135). Claimant responded: "I don't go to that hall any more than I have to. I get enough abuse from those people." (Tr. 35, 135). Funches nudged claimant and told him there was a member of the local union behind him, Mr. Strawn. (Tr. 35, 136). Claimant continued to complain and Strawn commented that claimant deserved what he was getting. (Tr. 35, 136). Claimant and Strawn continued to exchange derogatory comments until they boarded the bus. (Tr. 137). Claimant, Funches and Strawn boarded the same bus. Claimant and Strawn did not exchange any comments on the bus. (Tr. 55, 137, 169).

The bus arrived at the employer's parking lot at approximately 4:15 p.m. (Tr. 24). Mr. Smith had been on the same bus as claimant, Funches and Strawn. Smith testified that, as he was waiting to get off the bus, he saw claimant and Strawn outside by the cars. (Tr. 65). Claimant was in front of Strawn and claimant turned around and attacked Strawn. (Tr. 65, 70, 93, 179, 180, 182). Claimant and Strawn continued fighting. By the time Smith got off the bus to help break up the fight, claimant was getting up and Strawn was on the ground with a broken ankle. (Tr. 66). Claimant suffered a a right thumb, left ring finger, back and jaw injury. Both claimant and Mr. Strawn were fired by the employer.

On November 13, 1997, the employer denied the claim on the basis that it did not arise out of and in the course of claimant's employment. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was an "active participant" in the fight and, therefore, he failed to establish that he had sustained a compensable injury. *See* ORS 656.005(7)(b)(A).

On review, claimant contends that he was not an "active participant" in the fight. He argues that the ALJ erred by concluding that Mr. Smith's testimony was more credible than claimant's testimony.

When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). After our *de novo* review of the record, we agree with the ALJ that Mr. Smith's testimony is more credible than claimant's testimony. Although claimant argues that there are several inconsistencies with Smith's testimony, we find that any such inconsistencies relate to collateral matters and are not sufficient to Smith's testimony concerning the fight between claimant and Strawn. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984), *rev den* 298 Or 597 (1985). Mr. Smith was an eyewitness to the assault and we find no evidence of bias. Smith testified that he knew claimant and Strawn only from riding the bus and he did not work with either of them. (Tr. 84-85).

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "in the course of employment" concerns the time, place, and circumstances of the injury; and (2) "arising out of employment" tests the causal connection between the injury and the employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). Both elements must be evaluated; neither is dispositive. *Id.*

We first examine the time, place and circumstances of the injury. An injury occurs "in the course of" employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 598 (1997). "In the course of" employment also includes a reasonable period of time after work for the worker to leave the employer's premises, including the employer's parking lot. *Id.*

Claimant's work hours were from 6:00 a.m. until 4:30 p.m. (Tr. 18). The general practice was to start lining up to turn in the brass tokens shortly after 4:00 p.m. and the buses began leaving for the parking lot between 4:05 p.m. and 4:10 p.m. (Tr. 22). The employees were paid until 4:30 p.m. (*Id.*) Claimant testified that most days he was out of the parking lot completely by 4:15 p.m. (Tr. 19). On October 8, 1997, claimant said he was injured at approximately 4:15 p.m. (Tr. 24). Under these circumstances, we find that claimant was injured during working hours or alternatively, during a reasonable interval after working hours.

Next, we consider the place of claimant's injury. The injury occurred at the parking lot. Claimant testified that the parking lot was about a mile away from the job site and the employer contracted with a bus company to transport the workers between the parking lot and the job site. (Tr. 16-17). Claimant testified:

> "You're considered on the clock as soon as you board the bus because although your workday for the most part is 6:00 a.m. until 4:30, you're -- you're on these buses, which are paid for by the company. *The parking lot is considered company property.* The buses are considered part of the employ because while you're on the bus, if something would happen as far as getting hurt or an incident or accident, it is also an extension of the company property, the jobsite and naturally on company time." (Tr. 18; emphasis added).

Claimant also testified that union rules provided that employees are employed until they are off the company property at the end of the day. (*Id.*)

The employer did not offer any persuasive evidence to indicate that the parking lot was *not* considered part of the employer's property.[1] The only contrary comment was the question from the employer's attorney to claimant, asking if he was "aware that it was Hyundai that leased that parking lot, not [the employer]?" (Tr. 44). The employer, however, did not present any evidence to support that assertion. Claimant replied that he was not aware of that fact, although he was aware that employees other than those working for the employer also parked in that lot. (Tr. 45). Based on claimant's testimony, we conclude that his injury occurred on the employer's premises.

We also conclude that the circumstances of claimant's injury were in the course of his employment. The "in the course of employment" component is satisfied by the "parking lot rule," which provides that "injuries that occur on the employer's premises while the claimant is proceeding to or from work are 'in the course of employment.'" *SAIF v. Marin*, 139 Or App 518, 520, *rev den* 323 Or 535 (1996) (citing *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366-67 (1994) .

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[1] At hearing, claimant's attorney asserted that the sole issue was whether claimant was an active participant in an assault or combat. (Tr. 12). The employer's attorney responded:

> "Virtually I'd agree. Although, this is a parking lot incident, too. So that gets thrown into the mix as to whether he was within the course and scope of his employment because it happened in the parking lot, but it's primarily whether he was an active participant is the proper defense." (*Id.*)

Although the employer apparently was relying in part on the "parking lot" defense, the employer did not present any evidence to rebut claimant's statement that the parking lot was considered "company property."

The "arising out of" employment element concerns the causal connection between the injury and the employment. *Fred Meyer, Inc. v. Hayes*, 325 Or at 596. In *Redman Industries, Inc. v. Lang*, 326 Or 32, 39 (1997), 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 claimant's 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.*

In *Donald Converse*, 50 Van Natta 1830 (1998), *on recon* 50 Van Natta 2067 (1998), the claimant was a supervisor who had been critical of the quality of a project completed by a member of his work crew. In criticizing the employee, the claimant used profanity, an action for which he had previously been reprimanded. In response to the claimant's comments, the employee removed his safety glasses, pointed them at the claimant, and requested to be left alone. When the employee turned to return to his post, the claimant hit the glasses out of the employee's hand. Thereafter, the employee turned back to the claimant, grabbed him by the throat, and pushed him back into a post, causing the claimant's injury. We determined that, because the claimant's dispute concerned an employee's work product and the altercation arose as a part of that dispute, the "arising out of" element of ORS 656.005(7)(a) had been satisfied.

Here, claimant was injured in a fight with a coworker. A preponderance of the evidence indicates that the altercation resulted after claimant and Mr. Strawn had a disagreement about the local union. We find no evidence of any other motive for the assault or evidence that claimant and Strawn had any contact or relationship separate and apart from the work place. In fact, claimant testified that he had never seen Strawn before October 8, 1997. (Tr. 34, 36, 45). Under these circumstances, we find that the injuries claimant sustained in the assault arose in the course of his employment. *See Redman Industries, Inc. v. Lang*, 326 Or at 39-40; *Donald Converse*, 50 Van Natta at 1832.

We next address whether the injuries are excluded by ORS 656.005(7)(b)(A), which 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[.]"

ORS 656.005(7)(b)(A) "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." *Redman Industries, Inc. v. Lang*, 326 Or at 38 (emphasis in original). Unless both of those elements are met, the exclusion does not apply. *Id.*

Where, as here, claimant has shown that his assault-related injuries arose out of and in the course of employment, the burden shifts to the carrier to prove that the exception in ORS 656.005(7)(b)(A) applies. *Donald Converse*, 50 Van Natta at 1832. To defeat a finding of compensability, the employer must establish by a preponderance of the evidence that the 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. *Id.*

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).

Here, we find that the employer has established that claimant was an "active participant." Claimant and Strawn exchanged some disparaging remarks while waiting in line to board the bus. Based on Mr. Smith's testimony, we find that, after claimant and Strawn got off the bus, claimant turned around and attacked Strawn. (Tr. 65, 93). Smith testified that he saw claimant turn around and shove Strawn, and Strawn lunged at claimant and they continued to scuffle. (Tr. 75, 76, 93). Smith did not observe Strawn making any physical motions toward claimant before claimant attacked Strawn. (Tr. 77-78). Smith's testimony is consistent with that of Mr. Strawn, who agreed with his previous statement that claimant had shoved him first. (Tr. 179, 182). We conclude that claimant initiated the fight and was an "active participant" pursuant to ORS 656.005(7)(b)(A).

Next, we address whether the assault was "connected to the job assignment" and whether it amounted to a "deviation from customary duties." In *Donald Converse*, 50 Van Natta at 1833, we explained that the statutory exception under ORS 656.005(7)(b)(A) requires that the assault be separate from, and not linked or joined with, the claimant's assigned duties. In *Converse*, we relied in part on the Court's comments in *Redman Industries v. Lang*:

> "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 in original).

Here, claimant's job was to cut and fabricate unistrut, a light-gauge structural steel. (Tr. 14). His job was to have the steel cut and ready for the workers that were in the fabrication building of the plant. (*Id.*) Claimant was a member of a union, Plumbers and Steam Fitters Local 342 out of California. (Tr. 15). The record establishes that, shortly before the assault, claimant and Strawn had been discussing the local union and claimant had been complaining about his treatment by the local union. Although the assault apparently grew out of a quarrel about the local union, we find that the assault was separate from, and not linked or joined with, claimant's assigned duties. The subject matter of the assault was not directly related to claimant's job assignment of cutting and fabricating steel. Moreover, claimant and Strawn had never even worked together and did not know each other prior to October 8, 1997. We conclude that the assault was *not* connected to claimant's job assignment.

Finally, we must examine whether claimant's assault amounted to a deviation from his customary duties.[2] Claimant testified that he was aware that the employer had a rule that no fighting or anything of the sort was allowed. (Tr. 30, 31). The penalty for violating that rule was termination. (*Id.*) Claimant testified that the employer's rule against fighting was in the orientation packet. (Tr. 32). Mr. Smith also testified that employees would get fired for fighting on the job. (Tr. 94). We find no evidence that claimant's customary duties of cutting and fabricating steel included fighting. In light of the employer's policy prohibiting fighting, we conclude that claimant's assault amounted to a deviation from his customary duties.

In sum, we conclude that claimant was an active participant in an assault that was *not* connected to the job assignment and which amounted to a deviation from customary duties. Therefore, his claim is not compensable under ORS 656.005(7)(b)(A).

ORDER

The ALJ's order dated April 7, 1998 is affirmed.

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[2] In *Donald Converse*, it was not necessary to decide whether the assault amounted to a deviation from the claimant's customary duties in light of our determination that the statutory exclusion did not apply because the assault was connected to the claimant's job assignment.

October 27, 1998 Cite as 50 Van Natta 2095 (1998)

In the Matter of the Compensation of
VICTOR SCHUNK, Claimant
Own Motion No. 98-0383M
OWN MOTION ORDER OF ABATEMENT
Floyd H. Shebley, Claimant Attorney

Claimant requests reconsideration of our October 15, 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 required or currently requires surgery or hospitalization for treatment now or in the near future.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DARYL L. UNDERWOOD, Claimant
Own Motion No. 98-0232M
OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On June 5, 1998, the SAIF Corporation submitted claimant's claim for an alleged worsening of his September 10, 1992 compensable L4-5 disc herniation. Claimant's aggravation rights on that claim expired on February 24, 1998. SAIF recommended that the claim be reopened for own motion relief. On June 9, 1998, we issued our Own Motion Order, which authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. We also instructed SAIF to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

Subsequent to the reopening of claimant's own motion claim, claimant's claim for a new injury was litigated before Administrative Law Judge (ALJ) Podnar. By Opinion and Order dated September 4, 1998, ALJ Podnar found that claimant had sustained a new injury (recurrent L4-5 disc herniation) while working at subsequent employer (also insured by SAIF). (WCB Case No. 98-04106). SAIF requested our review of ALJ Podnar's September 4, 1998 order.

On October 6, 1998, SAIF requested that we withdraw our June 9, 1998 Own Motion order because claimant's current condition was found to be compensably related to a new injury at a subsequent employer. We treat SAIF's request as a request for reconsideration.

On October 12, 1998, we requested the parties' position regarding SAIF's request for reconsideration of our June 9, 1998 order and SAIF's appeal of ALJ Podnar's order. Claimant responded by letter dated October 19, 1998 and stated that, although SAIF requested our review of ALJ Podnar's order, it limited the scope of review to the issue of attorney fees only. SAIF has not disputed that representation, which is further confirmed by SAIF's request for review which expressly states that it is seeking review of only that portion of the ALJ's order that awarded an attorney fee.

In extraordinary circumstances, we may, on our own motion, reconsider a prior order. OAR 438-012-0065(2). Under the facts of this case (*i.e.* a "post-Own Motion Order" determination that another carrier is responsible for the condition on which own motion relief is granted and no opposition from the parties), we find that extraordinary circumstances exist that justify reconsideration of our prior order. Therefore, we withdraw our prior order and issue the following order in its place.

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 light of the parties' respective positions in this case, as well as in WCB Case No. 98-04106, we conclude that it is undisputed that claimant's current L4-5 disc herniation is unrelated to his September 1992 compensable injury. Thus, we are without authority to reopen claimant's 1992 claim. *See* ORS 656.278(1)(a).

Accordingly, on reconsideration, we deny the request for own motion relief. 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 E. ANDERSON, Claimant
WCB Case No. 97-08529
ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our September 30, 1998 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) *res judicata* ruling. Specifically, the ALJ concluded that a September 4, 1987 Stipulation and Order did not create a claim preclusion bar to claimant's litigation of his C6-7 disc condition.

In its request for reconsideration, the insurer asks us to expressly address the *res judicata* argument set forth in its brief on review. In that argument, the insurer relies on the alleged preclusive effect of the September 4, 1987 Stipulation and Order, and also argues that a subsequent "1993 Stipulation and Order should likewise act as a bar to litigation of compensability of claimant's current condition, on the same grounds." In response, claimant contends that the *res judicata* issue is beyond the proper scope of our review because it was first raised on the record during closing argument.

We agree that the *res judicata* issue is beyond the proper scope of our review. The insurer did not file a responsive pleading for hearing raising the *res judicata* issue, and it did not discuss that issue on the record in its opening remarks at hearing. We have previously concluded that an ALJ acted correctly in not addressing a preclusion theory that was not placed before him on the record. *Kenneth L. Devi*, 49 Van Natta 108 (1997). Moreover, we have consistently declined to consider an issue raised for the first time during closing argument. *See Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995). In accordance with the rationale expressed in these cases, we conclude that the *res judicata* argument advanced by the insurer in this case is beyond the proper scope of our review.

Moreover, as an alternative basis for our decision, we continue to adopt the ALJ's *res judicata* analysis. In particular, we agree with the ALJ's finding that the medical record in existence at the time of the September 4, 1987 Stipulation and Order did not relate claimant's C6-7 disk condition to the compensable injury. In so doing, we reject the insurer's argument that Drs. Havlina and Green related this condition to the injury. In opining that claimant's cervical condition was related to his injury, these doctors were addressing claimant's separate C3-4 disk condition. *See, e.g.*, Ex. 12A.

Finally, claimant's attorney is entitled to an additional assessed fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for these services is $300, payable by the insurer. In reaching this conclusion, we have particularly considered the time spent in responding to the insurer's request for reconsideration (as represented by claimant's written response), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our September 30, 1998 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our September 30, 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
ROBERT E. ANDERSON, Claimant
WCB Case No. 97-0438M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

The insurer submitted claimant's request for temporary disability compensation for his compensable left shoulder strain and C3-4 disc herniation. Claimant's aggravation rights on that claim expired on May 12, 1991.

On September 17, 1997, the insurer denied the compensability of claimant's current left C6-7 disc herniation. Claimant requested a hearing. (WCB Case No. 97-08529). The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated March 17, 1998, Administrative Law Judge (ALJ) Otto set aside that portion of the insurer's September 17, 1997 denial which pertained to the compensability of his C6-7 disc herniation. The insurer requested Board review of that portion of ALJ Otto's order which set aside the insurer's denial of claimant's C6-7 disc herniation. We issued an order on September 30, 1998, affirming that portion of ALJ Otto's order which set aside the insurer's denial of claimant's C6-7 disc herniation. The insurer requested reconsideration of our September 30, 1998 order. By an order on reconsideration issued on this date, we adhere to and republish our prior 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.

On July 11, 1997, Dr. Krautheim, claimant's treating physician, opined that claimant's current symptoms were due to his disc herniation at C6-7 with nerve root compression on the left at C7. He recommended a cervical foraminotomy on the left at C6-7. As we have determined that claimant's C6-7 disc herniation is compensability related to his accepted injury, we are persuaded that claimant's compensable injury worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1985 injury 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
VIRGILLIA K. EKDAHL, Claimant
WCB Case No. 98-01337
ORDER ON REVIEW
Jensen, Elmore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members *en banc*.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that found that claimant's "patronage dividends" were wages and should be included in the calculation of claimant's temporary disability rate. On review, the issue is rate of temporary disability compensation. We affirm.

FINDINGS OF FACT

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

Burley Design Cooperative is a worker-owned and operated cooperative, organized and incorporated under the Oregon Cooperative Corporation Act, ORS Chapter 62. To become a full member of the cooperative, a trial member must pay a membership fee of $2,500 in exchange for one share of no par stock. Each member may own only one share of stock and the right of stock ownership is conditioned upon being a member of the corporation. (Ex. 2-5, -7).

Under its bylaws, within eight and a half months after the close of its taxable year on January first, the cooperative is required to distribute to its members or former members 100 percent of its earnings on the value of patronage measured in hours worked during the year. (Ex. 2-19). The patronage dividends are paid in money, check, or written notices of allocation. At least 50 percent of each member's annual patronage dividend is paid in written notice(s) of allocation which are retained in the member's revolving capital account. (Ex. 2-20). The cooperative has unrestricted use of the revolving capital accounts, and redemptions are made at the discretion of the Board of Directors. (*Id.*) After two years of crediting patronage dividends to the member's capital account, the credited amount is converted into a 12-year unsecured debt ("Cooperative Note") of the cooperative to the member. The cooperative paid simple, annual interest on the note. (Ex. 2-20, -21).

If there was a loss at the close of the taxable year, the losses were allocated to the members based on hours worked during the year. These allocations were made in writing by a Notice of Negative Patronage Dividend and became payable within 30 days, or simple, annual interest accrued. (Ex. 2-21). The cooperative retained a security interest in members' revolving capital accounts for any other outstanding financial obligations due from the members to the cooperative, and had the right to offset those outstanding amounts against a member's obligations to the cooperative. (Ex. 2-24).

Members also consented to the payment of federal taxes on the patronage dividends made in qualified written notices of allocation in the taxable year when such distributions were received. (*Id.*)

Claimant began working for the employer/cooperative in 1990 as a seamstress and became a member of the cooperative. On April 2, 1996, the cooperative adopted Restated By-laws. (Ex. 2). On April 27, 1996, claimant experienced a compensable cervical and right humerus strain. (Ex. 4). She was temporarily disabled, totally or partially, from the date of injury into February 1998. At the time of injury, claimant was paid an hourly rate of $10.75. She also received patronage dividends as authorized under the cooperative's by-laws.

SAIF paid temporary disability benefits based on claimant's average weekly wage for the 52 weeks prior to injury, as established by the cooperative's payroll records of time worked, at the hourly rate of $10.75.

SAIF did not consider claimant's patronage dividends in computing the rate of her temporary total disability compensation, contending that they were not "wages." Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that "patronage dividends" received by claimant should be included as "wages" for the purpose of calculating claimant's temporary disability rate. The ALJ reasoned that the mandatory allocation of patronage dividends to the cooperative members based on hours worked was an

integral part of the employer's wage structure, and, because the patronage dividends placed in claimant's capital account could be readily be converted into a cash equivalent, it was a money rate and satisfied the meaning of "similar advantage" under ORS 656.005(29).

On review, SAIF presents several arguments that "patronage dividends" are not "wages." We disagree with SAIF's contentions for the following reasons.

Temporary total disability compensation is computed as a percentage of a worker's "wages." ORS 656.210(1). "Wages" is defined as "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 * * *." ORS 656.005(29).

SAIF first argues that, because "patronage dividends" are based on profits, they more closely resemble an ownership interest than a payment for labor. However, the cooperative pays its "patronage dividends" based on the number of hours that a member works. If a member does not work he or she receives no "patronage dividend." This is in contrast to ownership of stock where a stock dividend is paid based on the number of shares owned and not on hours worked.

In addressing this issue, we find instructive the Court's discussion of the distinction between an organization designed for corporate profit and a cooperative corporation in *Linnton Plywood Ass'n v. State Tax Commission*, 241 Or 1, 4 (1965). The Court cited *Packel, Law of Cooperatives*, 3rd ed., § 1, p. 1, in noting that "'[o]ne of the features which distinguish a cooperative from other forms of biparty organizations is the absence of capital profit.'" The Court also cited with approval the following definition of cooperatives in *Encyclopedia Americana* (1957 ed.) Vol. 7, at page 639:

> "'A cooperative is an organization established by individuals to provide themselves with goods and services, or to produce and dispose of the products of their labor. The means of production and distribution are thus owned in common and the earnings revert to the members, not on the basis of their investment in the enterprise but in proportion to their patronage or personal participation in it. Cooperatives may be divided roughly into consumer cooperatives and producer cooperatives.
>
> "'Consumer organizations operate for the benefit of the members in their capacity as individual consumers. * * *
>
> "'Producer organizations operate for the benefit of the members in their capacity as producers. Their function may be either the marketing or processing of goods produced individually (as in fishermen's or farmers' marketing associations, or associations which make butter or cheese from farm products received from farmer members), or the marketing of goods processed or produced collectively (as in the so-called workers' productive associations operating factories or mills).'"

The cooperative in this case is a producer organization engaged in the marketing of goods produced collectively. This purpose of organization was recognized by the legislature in enacting ORS 62.415 which states:

> "* * * net proceeds or savings on patronage of the cooperative by its members shall be apportioned and distributed among those members in accordance with the ratio which each member's patronage during the period involved bears to total patronage by all members during that period * * *. For the purposes of this section *work performed as a member of a workers' cooperative* shall be deemed to be patronage of that cooperative." (Emphasis added).

In addition, the court's decision in *Assoc. Reforestation v. State Workers' Comp. Bd.*, 59 Or App 348, 354, *rev den* 294 Or 295 (1982), is similarly instructive. In that case, members of Hoedads, Inc., a cooperative corporation engaged in reforestation, argued that the "patronage dividends" which each received should be treated, for purposes of the Workers' Compensation Law, not as "remuneration" but as incident to an ownership interest in the cooperative. Hoedads argued that, in the absence of profits, members might not receive any compensation for their services. The court held that Hoedads was subject to the Workers' Compensation Law:

> "' * * * The legislature chose the broad word 'remuneration' to define a subject employer; we see no reason that the recompense that a worker receives for his labor should not be considered remuneration just because the amount varies with the profits of the organization.
>
> "'* * * * *
>
> "' * * * [Members] may be thought of as having a proprietary interest in the cooperative, for the period in which they are members, but this is not inconsistent with what remains in essence an employer-employe relationship.'"

This principle was expanded by the court in *Employment Div. v. Surata Soy Foods, Inc.*, 63 Or App 221, 225-26 (1983), in determining that members of a cooperative were employees. The court stated that a cooperative which paid its members patronage dividends based on the number of hours worked was providing remuneration for that work, even if the members received no compensation.

The *Surata* court reasoned as follows:

> "Under the Workers' Compensation Law, ORS 656.005(28), 'worker' means any person who furnishes services for a 'remuneration,' subject to the direction and control of an employer. 'Employe,' under the Unemployment Insurance Law, ORS 657.015, means any person employed for 'remuneration' under a contract of hire by an employer. Services performed by an individual for 'remuneration' are deemed to be employment. ORS 657.040. Although the members of Surata performed services in return for patronage dividends, which are a share of profits in proportion to the amount of work performed, and in the absence of profits might not receive any compensation, we hold they were receiving 'remuneration' within the meaning of ORS 657.015."

Thus, the court concluded that an employee may be receiving recompense for services even though no "money" profit may be made.

Similarly, in this case, under the Workers' Compensation Law, ORS 656.005(28), a "worker" means any person who furnishes services for a "remuneration," subject to the direction and control of an employer. "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." ORS 656.005(29).

Here, the contract of hiring in force at the time of claimant's accident provided for both an hourly wage and patronage dividends as recompense for her performance of services, in proportion to the hours she worked. Thus, we conclude that, although claimant, as a member of the cooperative, performed services in return for patronage dividends, and in the absence of profits might not receive any compensation beyond her hourly wage, her patronage dividends are "wages" for the purpose of calculating her temporary disability benefits.

SAIF next argues that, because a portion of the "patronage dividend" is retained for a period of time by the cooperative, the "patronage dividend" is a return of shareholder equity, not a wage. Again, the Court's reasoning in *Linnton Plywood* is instructive in regard to SAIF's argument.

In *Linnton*, the question presented was whether or not the moneys retained by the cooperative corporation, upon which patronage credits were issued to the member-workers, were a part of the income of the corporation or were the property of the member-workers for the purposes of taxation. 241 Or at 3. The Court stated:

> "[I]n the absence of legislation to the contrary, the worker-members of a cooperative are considered the producers of the income. This is particularly true of th[is] corporation which was organized for the specific purpose of providing the highest income possible to its worker-members for work and labor done in producing manufactured goods for sale. Under such an arrangement all of the income produced through the labors of its members should be treated as the property of its member-workers." (Citations omitted.)

The Court held that the earnings of the cooperative corporation created by its workers are the earnings of its worker-members and cannot be considered as a part of the income of the corporation. *Id.* at 9.

In this case, as in *Linnton*, the same principle governs. The earnings of the cooperative corporation created by its workers are the earnings of its worker-members and, therefore, are a part of the wage rate by which claimant is compensated.[1]

Finally, SAIF argues that end of the year one-time bonuses are not to be included in the calculation of compensation. OAR 436-60-0025(5)(f), however, provides that bonus pay which is part of a written or verbal employment contract and which is designed to increase an employee's pay, is to be considered in determining the worker's wage. In the case of the cooperative, should we consider claimant's patronage dividend as a bonus, such an allocation is both a means to increase the worker's wages, and is incentive pay for claimant, and, as such is to be considered in determining her wages. *See Paula M. Paterson*, 42 Van Natta 1302, 1304-05 (1990).

In sum, we conclude that claimant's "patronage dividend" is "wages" for the purpose of determining her temporary disability rate.

Claimant's attorney is entitled to an assessed fee for services on review for successfully defending the wage rate issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the 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 4, 1998 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,500, to be paid by the SAIF Corporation.

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[1] Our decision receives additional support from the enactment of Subchapter T of Chapter 1 of the Internal Revenue Code, as amended. This Subchapter treats patronage dividends as income taxable to the members of the cooperative corporation in the taxable year when such distributions are received. *See* U.S.C. 1385(a)(1); *see also* Ex. 2-24, Bylaw 9.5, in which all members consent to such taxable treatment by reason of their membership in the cooperative.

We also note that the Court in *Linnton* rejected the argument that because actual receipt of retained patronage dividends (capital account moneys) were so contingent, they could not be considered as income until an actual spendable distribution of the asset had been made. 241 Or at 8, 9.

In the Matter of the Compensation of
DUSTIN L. CROMPTON, Claimant
Own Motion No. 97-0523M
FOURTH OWN MOTION ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

On October 1, 1998, we republished our December 11, 1997 order, as reconsidered January 21, 1998 and March 19, 1998, that authorized reopening of claimant's claim to provide temporary total disability compensation beginning March 12, 1997, the date he was hospitalized for surgery.

The parties have submitted a Disputed Claim Settlement (DCS), which is designed to resolve a compensability dispute pending at the hearing level. (WCB Case No. 98-___S.) Pursuant to that settlement, the parties agreed that the self-insured employer's denial "shall forever remain in full force and effect and the claimant's Request for Hearing thereon shall be dismissed with prejudice as to all issues raised or raisable between the parties." The parties' settlement has received ALJ approval.

The parties have also submitted a Claim Disposition Agreement (CDA) in which claimant releases his "non-medical services" rights to benefits (including temporary disability) for his December 1990 compensability claim. The CDA includes a provision that, on its approval, this Own Motion case "shall be dismissed." The parties' CDA has received Board approval.

Under these circumstances, we consider the parties' submission of these agreements as a request for reconsideration of our prior orders. After further consideration, we issue the following order. Based on the approved DCS, the employer's denial of claimant's current condition, including the L4-5 disc condition, is not compensable. Moreover, based on the approved CDA (including the aforementioned provision described above), claimant's request for temporary disability has become moot. Accordingly, on reconsideration of our prior orders, claimant's request for Own Motion relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CURTIS R. STEPHENS, Claimant
WCB Case No. 98-01552
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's partial denial of claimant's injury claim for left leg pain, left groin strain, and left thigh strain conditions. With his brief, claimant submits "post-hearing" documents, contending that the ALJ should have addressed the compensability of his left femoral neck fracture. The employer responds that the ALJ properly declined to address the latter issue because claimant waived it at hearing. The employer also submits "post-hearing" documents.[1] On review, the issues are scope of review, evidence (remand), and compensability.

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

At the outset of the May 11, 1998 hearing, claimant stated that he was only contesting the employer's denial of three conditions: left leg pain, left groin strain, and left thigh strain. He specifically stated that he was not claiming other denied conditions "at this time." (Tr. 1-2). After the ALJ's May 19, 1998 Opinion and Order, claimant requested reconsideration, moved to supplement the record with a May 27, 1998 medical arbiter's report (Proposed Exhibit 24), and asked the ALJ to consider the compensability of claimant's left femoral neck fracture. The ALJ denied claimant's requests.

On review, claimant argues that the employer's denial of his left femoral neck condition should be set aside, based on the medical arbiter's "post-hearing" report. Claimant contends that the latter proposed evidence should be admitted and the compensability of the left femoral neck should be considered, because the "post-hearing" report constitutes new medical evidence which was not available at the time of hearing (and there was no medical evidence supporting the compensability of the left femoral condition until the medical arbiter's post-hearing report issued).

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's submission of evidence as a motion to remand to the ALJ for the taking of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985). We consider the proffered evidence only for the purpose of determining whether remand is appropriate.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for

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[1] The employer submits a February 9, 1998 medical report by Dr. Farris, concurrence letters signed by Drs. Smith and Adams, and a copy of claimant's September 11, 1997 "801" form. The latter document is already in the record. (Exhibit 3). Two of the former documents address the cause of claimant's left femoral neck condition. Because the employer first contends that the compensability of the femoral neck condition was not timely raised at hearing, we treat its "post-hearing" submissions as proposed evidence intended to support an alternative contention that the condition is not compensable. We have determined herein that the issue was not timely raised, the ALJ properly refused to admit Proposed Exhibit 24, and remand is not appropriate. Consequently, we do not consider the employer's alternative argument or its proposed "post-hearing" evidence.

consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Although evidence that is not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton*, 301 Or at 648-49 (Neither erroneous factual foundation nor change of opinion creates unobtainable evidence; thus, even though certain medical reports were not available at the time of hearing, the substance of the reports was obtainable); *William R. Wallace*, 49 Van Natta 1078 (1997), *aff'd mem, Wallace v. Owens-Illinois, Inc.*, 136 Or App 547 (1995), *rev den*, 322 Or 490 (1996); *James E. Gore*, 45 Van Natta 1652 (1993) ("[E]vidence is not newly discovered merely because it was generated after the hearing.").

Here, at the outset of the hearing, claimant stated that he was not pursuing claims other than those for left leg pain, left groin strain and left thigh strain. Accordingly, because claimant did not contest the compensability of his left femoral neck condition, we conclude that the ALJ properly declined to address that issue when claimant attempted to raise it after the record closed. *See Valerie Barbeau*, 49 Van Natta 1189 (1997); *Connie M. Johnson*, 48 Van Natta 239 (1996).

Moreover, as claimant notes, no medical evidence supported the claim for a left femoral neck fracture at the time of hearing. Assuming (without deciding) that Proposed Exhibit 24 would support the compensability of the left femoral neck condition at hearing, there is no showing that the substance of the document was *unobtainable* at the time of hearing. *See Barbara J. Collins*, 47 Van Natta 1344, 1355 (1995) (Where a medical report generated after the hearing was based on information available at the time of hearing, it was not unobtainable as of the hearing). Under these circumstances, we conclude that the ALJ did not err in refusing to admit claimant's "post-hearing" evidence. *See Compton*, 301 Or at 648-649; *Gore*, 45 Van Natta 1652. Accordingly, after considering the ALJ's order, the record, and the parties' arguments, we cannot say that the record in this case has been improperly, incompletely or otherwise insufficiently developed and there is no compelling reason to remand. *See Lyster*, 79 Or App at 420.

ORDER

The ALJ's orders dated May 19, 1998 and June 30, 1998 are affirmed.

In the Matter of the Compensation of
JAMES M. VAN ATTA, Claimant
WCB Case Nos. 97-01641 & 97-01640
ORDER ON REVIEW
Malagon, Moore, 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) Otto's order that assessed an attorney fee for SAIF's allegedly unreasonable failure to request the designation of a paying agent pursuant to ORS 656.307(1). Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to award an assessed attorney fee for SAIF's allegedly "de facto" denial of his L4-5 disc injury; and (2) declined to consider certain issues raised by claimant in closing argument. On review, the issues are claims processing, penalties and attorney fees and hearing procedure. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On August 31, 1994, claimant compensably injured his left lower back. He sought treatment with Dr. Alaimo, who diagnosed a lumbosacral strain. An MRI scan showed a bulge at L4-5 but no disc herniations.

SAIF accepted a lumbar paravertebral muscular strain as a disabling injury. The claim was closed pursuant to an August 22, 1995 Notice of Closure, which awarded temporary disability only.

While at work on October 22, 1996, claimant experienced a sharp pain in his left lower back as he bent to his knees. He returned to Dr. Alaimo, who authorized time loss through November 18, 1996. Claimant then returned to light duty work.

A December 6, 1996 MRI scan of the lumbar spine revealed a small disc extrusion at L4-5, a disc bulge at L3-4 and a central disc protrusion at L4-5 of doubtful clinical significance. On January 22, 1997, Dr. Alaimo advised SAIF that claimant had a herniated disc at L4-5.

On February 5, 1997, SAIF issued a "Denial of Responsibility" which denied that claimant sustained a new injury on October 22, 1996, acknowledged that he had been diagnosed with a herniated disc at L4-5, and provided as follows:

> "It is our position that your condition(s) and need for treatment is the result of a separate injury claim under SAIF claim number 7802397K. SAIF Corporation will continue to pay for all benefits related to your L4-5 disc injury, which occurred on August 31, 1994.
>
> "SAIF Corporation has not requested the designation of a paying agent pursuant to ORS 656.307."

On February 14, 1997, Dr. Alaimo completed a Notice of Aggravation claim form on claimant's behalf.

On May 28, 1997, SAIF reopened claimant's lumbar paravertebral muscular strain claim. Thereafter, on June 4, 1997, claimant (through his counsel) wrote to SAIF, asking that it accept his L4-5 disc condition. SAIF responded by letter dated June 30, 1997, advising claimant that it had already accepted claimant's claim for an L4-5 disc injury as part of his August 31, 1994 injury claim.

On October 2, 1997, SAIF issued an "Updated Notice of Acceptance at Closure" listing the accepted conditions as lumbar paravertebral muscular strain and L4-5 disc injury.

CONCLUSIONS OF LAW AND OPINION

Penalty For Failure To Request ORS 656.307 Order

The ALJ found that, even though claimant's injury claims involved the same employer and same carrier, SAIF was required to comply with the requirements of ORS 656.307 and OAR 436-060-0180 and request the designation of a paying agent because it denied responsibility for the latter claim. The ALJ therefore assessed an attorney fee pursuant to ORS 656.382(1) based on SAIF's allegedly unreasonable resistance to the payment of compensation.

On review, SAIF asserts that ORS 656.307 and OAR 436-060-0180(2) do not apply to responsibility disputes involving multiple injuries but only one employer and one insurer, and therefore no penalty-based attorney fee is warranted for its failure to seek the designation of paying agent. We agree, for the reasons set forth below.

ORS 656.307(1) provides that, when all employers and insurers admit that the claim is otherwise compensable, the Department is required to issue an order designating "who shall pay the claim" where there is an issue regarding the following:

> "(A) Which of several subject employers is the true employer of a claimant worker;
>
> "(B) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;
>
> "(C) Responsibility between two or more employers or their insurers involving payment of compensation for one or more accidental injuries; or
>
> "(D) Joint employment by two or more employers."

Moreover, OAR 436-060-0180 requires, among other things, that a carrier, upon learning of any of the situations described in the statute, "shall expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable." OAR 436-060-0180(4). The rule further provides that "upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer shall request designation of a paying agent by applying in writing to the Division." OAR 436-06-0180(6).

In interpreting the statute, our task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 606 (1993). At the first level of analysis, we examine both the text and context of the statute. *Id.* at 610. If the legislative intent is not clear from that inquiry, we then examine the legislative history or other extrinsic aids. *Id.* at 611-12.

Here, the plain language of ORS 656.307(1)(a) and OAR 436-060-0180 indicates that the statute and rule apply when there is a responsibility issue involving "more than one insurer" or "two or more employers." By its terms, therefore, the ORS 656.307 does *not* apply to a dispute involving only one insurer of one employer. Indeed, to conclude otherwise, and find the statute is applicable where there is no question which employer and/or carrier is responsible, would necessitate inserting language into ORS 656.307 that we are forbidden by law to add. *See* ORS 174.010[1]; *Deluxe Cabinet Works v. Messmer*, 40 Or App 548, 553 (1996) ("We are forbidden, both by statutory command and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted.").

Because this case does not involve a responsibility dispute among two or more employers and/or insurers, it does not fall within the parameters of the statute. Insofar as we have determined that ORS 656.307 does not apply to the circumstances of this particular case, SAIF cannot be penalized for not complying with the provisions of OAR 436-060-0180. We therefore reverse that part of the ALJ's order which assessed an attorney fee based on SAIF's allegedly unreasonable failure to request designation of a paying agent pursuant to ORS 656.307.

Alleged "De Facto" Denial of L4-5 Disc Injury

The ALJ found that SAIF had accepted claimant's L4-5 disc condition as of June 30, 1997 and could not be assessed an attorney fee for a "de facto" denial of that condition. On review, claimant renews his contention that he made his disc injury claim as of mid-February 1997 and, because SAIF failed to accept or deny the claim within 90 days, he is entitled to an attorney fee under ORS 656.386(1).

Even assuming, without deciding, that claimant's February 1997 aggravation claim also constituted a "new medical condition" under ORS 656.262(7)(a) for his L4-5 disc condition, we are persuaded that SAIF had already acknowledged responsibility for that condition. In other words, unlike the ALJ, we find that SAIF's February 5, 1997 "Denial of Responsibility" also constituted an acceptance of the L4-5 disc injury.[2] In denying responsibility for a new injury occurring on October 22, 1996, SAIF took the position that claimant's L4-5 disc condition "is the result of a separate injury" under a different SAIF claim number, 7802397K. SAIF further advised claimant that it would "continue to pay all benefits related to [his] L4-5 disc injury, which occurred on August 31, 1994." We construe this portion of the denial as an acceptance of responsibility and an obligation to provide benefits for the disc condition (albeit as part of claimant's 1994 claim). Moreover, in its May 28, 1997 letter to claimant (sent in response to claimant's aggravation claim), SAIF specifically acknowledged that claim No. 7802397K had been reopened and that his aggravation claim "has been accepted."

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[1] ORS 174.010 provides in pertinent part that, "[i]n the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, [and] not to insert what has been omitted, or to omit what has been inserted * * *."

[2] Acceptance is an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. *See Richard L. Markum*, 48 Van Natta 2204 (1996); *Gene C. Dalton*, 43 Van Natta 1191 (1991). Whether an acceptance occurs is a question of fact. *SAIF v. Tull*, 113 Or App 449 (1992)

Finally, after receiving claimant's counsel's June 4, 1997 letter, SAIF responded, by letter dated June 30, 1997, that it had "already accepted" his claim for a L4-5 disc injury in its February 5, 1997 denial letter. Under these circumstances, we find there has been no "de facto" denial of the disc injury and claimant's attorney is not entitled to an assessed fee under ORS 656.386(1)(b)(C).[3]

Hearing Procedure

We adopt and affirm the ALJ's decision not to consider those issues raised by claimant for the first time in his initial closing argument. *See, e.g., Burton I. Thompson*, 48 Van Natta 866 (1996); *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995); *see also Donald A. Hacker*, 37 Van Natta 706 (1985) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy).

ORDER

The ALJ's order dated January 20, 1998 is affirmed in part and reversed in part. That part of the order that assessed a $500 attorney fee for SAIF's failure to request the designation of a paying agent pursuant to ORS 656.307 is reversed. The remainder of the order is affirmed.

[3] Pursuant to ORS 656.386(1)(b)(C), a "denied claim" includes a claim for a new medical condition made pursuant to ORS 656.262(7)(a) which the insurer or self-insurer does not respond to within 90 days.

October 29, 1998 Cite as 50 Van Natta 2107 (1998)

In the Matter of the Compensation of
JERRY E. MITCHELL, Claimant
WCB Case No. 97-07353
ORDER ON RECONSIDERATION
Linerud Law Firm, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

On October 9, 1998, we withdrew the Board's September 10, 1998 order that adopted Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of his claim for back and head injuries. We took this action to consider claimant's argument that the preponderance of the evidence established that he sustained a work-related injury. Claimant also argues that SAIF's denial "denied claimant's claim on the basis of course and scope only, and not whether an injury occurred." Having received SAIF's response, we proceed with our reconsideration.

With regard to claimant's first argument, we agree with, and have adopted, the ALJ's reasoning and conclusion that claimant failed to prove that he sustained a work-related injury. The ALJ's order thoroughly and completely addresses the evidence and claimant's arguments in reaching his conclusion. We have nothing further to add to the ALJ's order.

With regard to claimant's argument that SAIF's denial denied only that an injury occurred in the course and scope of employment, we have the following comments. The basis for SAIF's denial of the claim was that claimant's injury "did not arise out of or occur within the course and scope of [claimant's] employment." (Ex. 122). At hearing, SAIF argued that claimant did not sustain an injury at work (in the course and scope of his employment). Based upon the evidence, the ALJ agreed with SAIF's argument and found that no injury occurred at work. On Board review, SAIF continued to argue that no injury occurred at work and sought to have the ALJ's order affirmed. We find no inconsistency between the position taken in SAIF's denial and its arguments at hearing and on Board review that no injury occurred at work.

On reconsideration, as supplemented herein, we republish the Board's September 10, 1998 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALEX J. BANNON, Claimant
WCB Case No. 98-01957
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's denial, on behalf of the alleged noncomplying employer, of claimant's left knee injury claim. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

In 1992, claimant began working part-time for the employer corporation as a laborer, building decks. He was initially paid by the hour, later for "piece work," by the square foot. Claimant sometimes did jobs for other people between 1992 and his 1998 injury. He never worked under a contract.

The employer decided where claimant would work and told him what size and type of deck to build. (*See* Tr. 45-46). Then claimant did the building on his own. (Tr. 11, 56-57).

The employer could fire claimant at any time without liability. It provided tools and supplies for claimant's work and claimant sometimes charged materials to the employer. (*See* Tr. 20, 53, 56).

In late 1996, the employer offered claimant 10 percent ownership in the business and the title of vice-president, with the understanding that he would be exempt from worker's compensation coverage and this would allow him to receive a raise. Claimant received the raise. He understood that the employer would not provide workers' compensation coverage if he was a corporate officer and shareholder. But claimant never received stock certificates or any indicia of ownership. He performed none of the functions of a corporate officer or director. (*See* Tr. 62, 70-71, 76).

In July 1997, the employer listed claimant as an exempt corporate officer on a form filed with SAIF. (Ex. 1F).

On January 15, 1998, claimant fell at work and injured his left knee. He sought treatment and Dr. Buuck diagnosed a torn left anterior cruciate ligament. Claimant filed a claim, which SAIF denied.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was not a subject worker when he injured his left knee. The ALJ reasoned that the employer and claimant had agreed that claimant would be a corporate officer and director with a substantial interest in the company and therefore claimant could not be a subject worker. We disagree.

Because this is a subjectivity case, we must first determine whether claimant is a "worker" within the meaning of ORS Chapter 656. *S-W Floor Covering Shop v. National Council on Compensation Insurance*, 318 Or 614 (1994); *Charles J. Fields*, 43 Van Natta 263, 264 (1991) ("Only if claimant is a 'worker' within the meaning of the statute do we proceed to a discussion of the nonsubject worker exceptions contained in ORS 656.027.").

Under ORS 656.005(30): "'Worker' means any person * * * subject to the direction and control of an employer. . . . " *See S-W Floor Covering*, 318 Or at 630 ("The initial determination of whether one is a 'worker' * * * continues to incorporate the judicially created 'right to control' test.").

The factors to be considered under the traditional "right to control" test include: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire at will without liability. *Woody v. Waibel*, 276 Or 189 (1976).

In this case, the employer decided when and where claimant would work on its jobs. The employer told claimant what size and type of deck to build and claimant completed the work without further direction. The employer provided materials and tools for the jobs. Claimant did not work under a contract and the employer had the right to fire him any time. He was paid by "piece work" when injured and the method of payment did not change after the 1996 raise.

Considering the *"Waibel"* factors, we conclude that claimant was a "worker" under ORS 656.005(30) when he was injured. Accordingly, we next consider whether claimant was excluded from among "subject workers" because he was a corporate officer with a substantial ownership interest in the employer's business. *See* ORS 656.027(10).[1]

Claimant argues essentially that he should be considered a subject worker because he was a corporate officer/corporate owner in name only. We agree.

In *SAIF Corp. v. Cox*, 133 Or App 666, 671 (1995), the court explained that only "bona fide" corporate officers are excepted from subject worker status. "Sham" officers and directors are not excepted. *Id.* An officer of a corporation should have at the least some financial interest in the company and have a voice in its management. *See Carson v. State Indus. Acc. Comm.*, 152 Or 455, 459-60 (1936).

Here, although claimant agreed to become a corporate vice president, he never functioned as such. After the agreement, claimant continued to work as he had before. He was paid in the same manner as before. He never attended a meeting of corporate officers/directors and he had no voice in company management In fact, the employer never intended that claimant would have a voice in management decision making. (Tr. 62-64; 70-72).

Although the employer designated claimant as a corporate officer, the record establishes that the designation was a sham. We cannot say that claimant had a substantial ownership in the corporation either, because there is no indication that the promised 10 percent share was actually transferred to him. (Tr. 72). *See Roger D. McCommon, Jr.*, 40 Van Natta 1100, 1101 (1988) (No substantial ownership based on mere promise of future ownership). Under these circumstances, claimant was not a bona fide officer or director of the corporation and he did not have a substantial ownership in it. *See Kevin D. Cox*, 47 Van Natta 1326 (1995). Therefore, claimant was a subject worker when he was injured and his left knee injury claim is compensable.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF, on behalf of the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 11, 1998 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 $3,500 attorney fee, payable by the SAIF Corporation, on behalf of the employer.

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[1] ORS 656.027 provides in pertinent part that:

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

"* * * * *

"(1) * * * [C]orporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers."

In the Matter of the Compensation of
ROBERT L. DAWSON, Claimant
WCB Case No. 98-01089
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of claimant's left ankle injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following supplementation and summarization of the pertinent facts.

Claimant works for a school district as a "special needs" bus driver, transporting children with physical, mental, and emotional disabilities. Between bus runs, claimant works in the bus barn as a custodian two hours per day. Claimant's work schedule is very specific and if he needs to vary it, he is required to obtain permission from his supervisor. The school district has difficulty arranging for substitute drivers for the special needs bus. (Tr. 7).

The school district arranged to provide flu shots for its staff from 3:00 to 4:00 p.m. on October 28, 1997, at a high school health center. The staff was not required to take a flu shot. Because the bus drivers would be on their routes during the time the flu shots were being given to the other staff, the school district arranged to have their shots provided from 9:00 to 9:30 a.m.. Claimant was provided with notice in his "mail box" at the bus barn that he was scheduled for the 9:00 to 9:30 a.m. period. (Ex. 0, Tr. 5). Claimant's bus route extended into the 9:00 to 9:30 a.m. period, so he received his supervisor's permission to stop at the high school for a flu shot during his morning bus route. (Tr. 5-6).

Claimant injured his left ankle as he was returning to his bus after receiving his flu shot. The injury occurred as claimant was descending the stairs of the high school gymnasium. Claimant had to take that route out of the gymnasium because of construction at the high school. (Tr. 10). The railing along the stairs made a 100 degree turn at the end of the stairs. (Tr. 9). As claimant was holding onto the railing and stepping off of the final step onto ground level with his left foot, his left foot turned and rolled under him. (Tr. 9-11). By holding onto the railing, claimant was able to avoid falling to the ground. Claimant walked/hopped back to his bus and continued on with his route from there, without missing any work time. (Tr. 11, Ex. 3).

Claimant was paid for the time that he used to receive the flu shot. There was nothing about the stairs or ground that caused claimant to trip or turn his ankle. (Tr. 10-11).

Later that day, claimant was examined by Dr. Sager, who diagnosed "significant sprain of left ankle" and prescribed crutches. (Ex. 2). Subsequently, Dr. Sager diagnosed a nondisplaced fracture in addition to the left ankle sprain. (Ex. 4).

Claimant filed a claim for compensation the day after the incident. (Ex. 3). The insurer denied the claim on January 15, 1998, contending that the injury did not arise out of and in the course and scope of claimant's employment. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

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) "arising out of employment" tests the causal connection between the injury and the employment; and (2) "in the course of employment" concerns the time, place, and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). The phrases "arising out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Norpac Foods*, 318 Or at 366; *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). This is called the unitary "work-connection" test. Under that test, both elements must be satisfied to some degree; however, they need not be met to the

same degree. *Id.* Neither element is dispositive; rather, we consider all the circumstances to determine if the claimant has satisfied the work-connection test. *Norpac Foods*, 318 Or at 366, 369. When the factors supporting one element are many, the factors supporting the other may be minimal. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

The ALJ found that the injury was "in the course of employment" because it occurred both on the employer's premises and during work hours for which claimant was paid. We adopt the ALJ's reasoning and conclusions regarding that issue.

On the other hand, the ALJ found that the injury did not "arise out of employment" because: (1) the process of getting a flu shot that was arranged for but not required by the employer did not have any connection with claimant's work as a bus driver; and (2) nothing about the employer's work environment caused claimant's injury or put claimant in a position to be injured. Claimant disputes those findings. For the following reasons, we agree with claimant that the injury arose out of his employment.

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." *Norpac Foods*, 318 Or at 366. A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. *Id.* at 368; *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29 (1983). "A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed [the] claimant." *Redman Industries v. Lang*, 326 Or at 36 (*citing Fred Meyer, Inc. v. Hayes*, 325 Or at 601). Further, we no longer rely on the *Mellis* factors[1] as an independent and dispositive test of work connection; however, we may consider those factors that remain helpful under the *Norpac Foods*' analysis. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996); *First Interstate Bank of Oregon v. Clark*, 133 Or App 712, 717 (1995); *Mark Hoyt*, 47 Van Natta 1046, 1047 (1995).

Here, at the time of claimant's injury, claimant was engaged in an activity that was of benefit to the employer because having a flu shot could prevent claimant from getting the flu and missing work. Although the flu shot was not required by the employer, the employer arranged for, paid for, and encouraged claimant to get the shot. In this regard, the employer put a notice in claimant's "mail box" notifying claimant about the flu shots and noting that "we have you sched[uled] for 9:00 - 9:30 a.m. for those who cannot come @ 3:00." (Ex. 0). In addition, because claimant would still be on his morning bus route at the rescheduled time, his supervisor approved his stopping by the high school during his morning route to get a flu shot. Thus, the activity was contemplated by the employer and claimant. In addition, under these circumstances, the activity was at least acquiesced in, if not directed by, the employer. Furthermore, the activity occurred on the employer's premises and claimant was paid during the time he got the flu shot. Given this totality of circumstances, we find that the injury arose out of employment.

Finally, the ALJ found that there was nothing about claimant's work environment that specifically caused his injury or put him in a position to be injured because there was no evidence that the stairs were broken and no other specific impediment was identified. In making this finding, the ALJ relied on *James D. Johnson*, 48 Van Natta 303 (1996), *aff'd, Johnson v. Beaver Coaches, Inc.*, 147 Or App 234 (1997). We agree with claimant that the ALJ's reliance on *Johnson* is misplaced.

In *Johnson*, the claimant worked on a production assembly line. He injured his knee when he turned to take a step to return to his task after speaking to a coworker about a work matter. The shop floor was level and there was no evidence that the claimant slipped, twisted, or tripped over anything on the floor. The court affirmed our conclusion that the claimant failed to establish any causal connection other than the fact that the step occurred at work. *Johnson*, 147 Or App at 235.

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[1] In *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 574, *rev den* 300 Or 249 (1985), the court held that, in determining whether an injury arose out of and in the course of employment, the following seven factors should be considered: (1) whether the employment activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee; (3) whether the activity was an ordinary risk of, and incidental to, employment; (4) whether the employer paid for the activity; (5) whether the activity occurred on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission.

Subsequent to the *Johnson* decision, the Oregon Supreme Court advised us that Oregon has "rejected the largely obsolete 'peculiar-risk' and 'increased-risk' considerations in assessing whether a worker's injury was linked to a risk associated with employment." *Redman Industries v. Lang*, 326 Or at 36. In addition, the Court reminded us that "worker's compensation is a no-fault system that compensates a worker for injuries that arise out of and occur in the course of the worker's employment" and held that a claimant who injures herself while "skip-stepping" around a corner in the workplace has sustained an injury that arises out of employment, even in the absence of some particular hazard arising from the employer's premises. *See Wilson v. State Farm Ins.*, 326 Or 413 (1998); *David L. Starkey*, 50 Van Natta 906 (1998) (Board Chair Bock concurring).

Here, claimant was injured when he twisted his ankle on his way back to his bus to continue on his morning route after stopping to get an employer-arranged flu shot on the employer's premises. Notwithstanding the fact that the stairs were not broken and no other specific impediment was identified that caused claimant to turn his ankle, given the totality of circumstances, as addressed above, we find that claimant's injury occurred as a risk of his employment.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 14, 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 $4,200, payable by the insurer directly to claimant's attorney.

Board Member Moller dissenting.

Because I conclude that the "course of employment" element of the unitary work-connection test is weak and the "arising out of employment" element is absent, I respectfully dissent from the majority's holding in this case. *See David L. Starkey*, 50 Van Natta 906 (1998) (Member Moller's dissent).

In the Matter of the Compensation of
DAVID L. EASLEY, Claimant
WCB Case Nos. 98-02043 & 98-02042
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's partial denials of claimant's injury and occupational disease claims for a current low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order,[1] with the following supplementation.

We agree with the ALJ that the medical evidence does not relate claimant's current condition (or his need for surgery) to his 1996 lumbar strain. Moreover, even if claimant may rely on all his work activities -- including his 1996 and 1997 accepted strains and his heavy work from August 1987 through

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[1] But we do not discount Dr. Belza's opinion because it is a "concurrence letter." *See Roseburg Forest Products v. Glenn*, 155 Or App 318 (1998).

September 1995, when he elected against workers' compensation coverage[2] -- that would not aid claimant's cause. We reach this conclusion because no medical evidence establishes that claimant's work activities (or his work injuries and his work activities) were the major contributing cause of his L4-S1 problems or his need for L4-5 surgery. Consequently, the claim is not proven under ORS 656.005(7)(a)(A) or 656.802.

Claimant also argues that his current condition is compensable under ORS 656.005(7)(a) because his treating physicians did not state that he had a preexisting condition, but they did persuasively relate his current condition (and need for surgery at L4-5) to the accepted October 1997 strain injury. We find that claimant *did* have a preexisting condition and it combined with his work injury to cause his subsequent problems, as explained below.

Claimant had intermittent low back pain for several years before 1994. In August 1994, Dr. Eckman examined claimant and suspected chronic discogenic disease. (Ex. 21). An MRI showed decreased signal intensity consistent with "degeneration/dessication" at L4-5, and a herniation at that level. (Ex. 23). Dr. Eckman described claimant's August 1994 L4-5 condition as a "significant lesion" that "fits his clinical state." (Ex. 25). In October 1995, Dr. Eckman discovered a new disc protrusion at L5-S1 and an MRI revealed "'chronic appearing discogenic degeneration," similar to that seen in 1994. (Exs. 38, 39). In March 1997, Dr. James noted claimant's "predisposition" to low back strains. (Ex. 57-4). Later, he described claimant's January 1998 degenerative condition as "well-established" and "longstanding." (Ex. 83-5-6). On this evidence, we find that claimant had a preexisting low back condition before his October 1997 strain injury at work. (*See* Ex. 71). *See New Portland Meadows v. Dierenger*, 153 Or App 383 (1998) (preexisting means preceding an initial claim).

In December 1997, Dr. Eckman described claimant's then current problems as having "maximal impact at S1" with some involvement at L-5 "secondary to *chronic* recurrent disc at L4-5." (Ex. 70-2; emphasis added). A December 1997 MRI indicated degeneration, a herniated disc at L4-5 and a bulging disc at L5-S1. (Ex. 71). Dr. James opined that claimant's preexisting degeneration combined with the October 1997 work injury to cause claimant's subsequent problems. (Ex. 98-6-7). On this evidence, we find that claimant's preexisting degenerative condition did combine with the October 1997 work injury to cause his subsequent disability and need for medical services. Consequently, claimant is subject to the major contributing cause standard under ORS 656.005(7)(a)(B).

The remaining question is: Has claimant proven that the work injury was the major contributing cause of his 1998 need for surgery for his combined condition? We conclude that he has not, based on the following evaluation of the medical evidence.

Dr. Eckman opined that the 1997 injury caused claimant's current condition, because his most recent problems were at a different level than those in 1994-1995. (Ex. 96). We agree with the ALJ that Dr. Eckman's reasoning is not persuasive because claimant's problems emanated from his L4-5 disc in 1994 and early 1995 and from there again when Dr. Belza performed an L4-5 diskectomy on January 2, 1998. (*See* Ex. 75).

Dr. Belza opined that claimant's need for L4-5 surgery was related to the 1997 injury rather than "post 1994" degeneration primarily because there had been no gradual degeneration evident between the 1994-1995 and 1997 MRIs and no "pre October 1997" long-lasting low back symptoms, but there *was* a dramatic increase in symptoms after the 1997 injury. (Ex. 93). We do not find Dr. Belza's reasoning persuasive for three reasons.

First, as Dr. James pointed out, there is no way to tell how much claimant's L4-5 disc degenerated between the 1995 films and the October 1997 injury. (*See* Ex. 83-6). Second, although Dr. Belza stated that his conclusions were based on his own examination and operative findings, he did not explain how those findings implicated the 1997 injury more than claimant's longstanding degeneration. Finally, although Dr. Belza addressed claimant's "*post* 1994" degeneration, he did not mention (or weigh) claimant's well-established "*pre* 1994" degeneration in arriving at his "major cause" determination. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995); *Oreste A. Chorney*, 50 Van Natta 818 (1998) (Physician's opinion inadequately explained because he failed to weigh

[2] *See SAIF v. Gosda*, 155 Or App 120 (1998) (Claimant may rely on all occupational exposures to establish an occupational disease under the "Last Injurious Exposure Rule").

the contribution of the work injury as compared to the undisputed preexisting degeneration). Consequently, we conclude that Dr. Belza's causation opinion is inadequately explained and therefore unpersuasive.

In contrast, Dr. James considered claimant's history of injuries, symptoms and treatment, in light of his longstanding degenerative condition. He concluded that degeneration, rather than the 1997 injury, was the major cause of claimant's current condition. (Ex. 98). We find Dr. James' reasoning and conclusions persuasive because they are well-reasoned and based on an accurate history. Accordingly, based on Dr. James' persuasive opinion, we conclude that claimant has not proven that his compensable injury was the major contributing cause of his need for medical treatment or disability for his combined condition. *See* ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated July 1, 1998 is affirmed.

In the Matter of the Compensation of
PHYLLIS M. HAYS aka PHYLLIS M. MARTIN, Claimant
WCB Case No. 97-10014
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) directed the employer to pay temporary disability pursuant to a prior ALJ's order; and (2) assessed a 15 percent penalty for the employer's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties. We affirm.

FINDINGS OF FACT

In November 1991, claimant, a registered nurse, developed compensable post-traumatic stress disorder (PTSD) related to a motor vehicle accident occurring in the course and scope of her employment. Claimant's PTSD allegedly worsened in October 1995. On October 22, 1995, claimant's attending physician, Dr. Skipper, authorized temporary disability from September 5, 1995 through February 1, 1996. (Ex. 17).

The employer denied the aggravation claim and claimant's current condition on December 8, 1995. Claimant appealed the denial, which resulted in a hearing before a prior ALJ, who set aside the denial. The ALJ ordered the employer to process the claim pursuant to the law, "including, but not limited to, payment of temporary disability compensation." We affirmed the ALJ's order, with the exception of the attorney fee award, which was reduced. *Phyllis M. Hays*, 50 Van Natta 696, *on recon* 50 Van Natta 867 (1998).

In the meantime, on December 11, 1997, claimant requested a hearing, seeking temporary disability payments from the date of the prior ALJ's order (July 17, 1997), as well as a penalty.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant entitled to temporary disability payments pursuant to the prior ALJ's order. The ALJ reasoned that claimant's attending physician had authorized temporary disability and that none of the events listed in ORS 656.268(3) had occurred so as to allow the employer to cease paying benefits. Moreover, the ALJ determined that the employer's failure to pay temporary disability was unreasonable. The ALJ, therefore, assessed a 15 percent penalty.

On review, the employer contends that the ALJ incorrectly ordered it to pay temporary disability for several reasons. The employer asserts that no attending physician validly authorized temporary disability, that claimant withdrew from the labor market prior to her aggravation claim, and that the prior ALJ's order did not determine claimant's entitlement to temporary disability because temporary disability was not an issue in the prior hearing.

We do not address the employer's arguments regarding authorization of temporary disability or claimant's presence in the labor market when she filed her aggravation claim. Instead, we conclude that the employer was required to pay temporary disability pursuant to the prior ALJ's final order. We reason as follows.

The employer correctly observes that temporary disability was never an issue before the previous ALJ. (Ex. 26A). Yet, when the ALJ set aside the employer's current condition/aggravation denial, the ALJ ordered payment of temporary disability. (Ex. 26A-15). The employer requested review of the ALJ's order. But it did not seek correction of that portion of the order directing the employer to pay temporary disability. We affirmed the prior ALJ's order, with the exception of the attorney fee award. 50 Van Natta at 697.

Accordingly, we conclude that the employer was required to comply with the July 17, 1997 order directing it to pay temporary disability. *See Theodore W. Lincicum*, 40 Van Natta 11953, 1955 (1988) *aff'd mem, Astoria Oil Service v. Lincicum*, 100 Or App 100 (1990). Moreover, we agree with the ALJ's reasoning that none of the events listed in ORS 656.268(3) have occurred so as to allow the employer to terminate payment of temporary disability. Therefore, we also agree with the ALJ that the employer is required to pay temporary disability from July 17, 1997 until it is authorized by law to terminate benefit payments.

Finally, because the employer failed to comply with the prior ALJ's order, we further conclude that it unreasonably processed the claim. *See Karen S. McKillop*, 44 Van Natta 2473, 2474 (1992). Thus, the ALJ properly assessed a penalty.

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

ORDER

The ALJ's order dated April 28, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

October 29, 1998 Cite as 50 Van Natta 2115 (1998)

In the Matter of the Compensation of
ROBERT M. JAYNES, Claimant
WCB Case Nos. 97-06780 & 97-05977
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney
VavRosky, MacColl, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Business Insurance Company (BICO) requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's low back injury claim; and (2) upheld the SAIF Corporation's denial of claimant's current low back condition. On review, the issues are compensability and responsibility.

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

Claimant seeks a $2,000 attorney fee for services on Board review pursuant to ORS 656.382(2). BICO objects to the requested attorney fee as excessive.

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 a complex medical issue regarding the cause of claimant's current low back condition. Claimant's counsel indicates he devoted two full days to drafting his respondent's brief, which is 15 pages in length, and some amount less than half of another day of services in reviewing the appellant's brief. BICO argues that two days to draft the respondent's brief is excessive. There is no indication that claimant's counsel did not, in fact, spend the time asserted working on claimant's brief. Moreover, we note that time devoted to the case is only one of the eight factors to be considered in determining a reasonable fee.

The value of the interest involved and the benefit to claimant are substantial, in that claimant may require surgery to treat his compensable condition, which has resulted in temporary and potentially permanent disability. Considering the medical opinions, there was some 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.[2]

After considering these factors and BICO's objection, we find that $2,000 is a reasonable fee for claimant's attorney's services on review. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief and his attorney's statement of services), as well as the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated May 5, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $2,000, payable by BICO.

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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).

[2] Claimant argues that BICO asserted a frivolous argument by denying compensability. We disagree. BICO had at least a colorable argument that claimant did not sustain an injury at its insured in April 1997. In this regard, the earliest medical reports did not record the incident and there were inconsistencies in claimant's truck logs for the date of the injury that cast doubt on the injury. Although the ALJ resolved these inconsistencies and found that claimant's account of the injury was credible based on his demeanor, BICO's arguments to the contrary were not frivolous given this record.

In the Matter of the Compensation of
VLADIMIR D. LAZARENKO, Claimant
WCB Case No. 97-05889
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of claimant's claim for injuries resulting from a workplace altercation. On review, the issue is whether claimant's injuries arose in the course and scope of employment. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of pertinent facts.

Claimant worked as a carpet-layer for two years before April 21, 1997. That day, claimant, his supervisor and a co-worker were laying carpet in a residence. At about 4 p.m., in the large closet they were carpeting, claimant told the co-worker that it was time to stop working. The supervisor overheard him and commented that the work day ran until 4:30. Claimant and his supervisor then argued heatedly about the proper quitting time. During the course of the argument, claimant criticized his supervisor, using blunt terms. Claimant also became very agitated, waved his hands in the air, stamped his feet, and used profanity. Eventually, the supervisor told claimant to go home.

The argument started in the closet, claimant followed his supervisor out once, still arguing, and claimant preceded his supervisor back into the closet as the argument continued for about 20 minutes. Then claimant's supervisor struck him in the face. Claimant sought medical treatment and filed a claim.

Based on *Redman Industries, Inc. v. Lang*, 326 Or 32, 40 (1997), the ALJ implicitly decided that claimant's injury arose out of his employment, reasoning that the "risk of an assault by a co-employee in the workplace is a risk to which the work environment exposes an employee." But the ALJ concluded that the claim was not compensable under the exclusion set out in ORS 656.005(7)(b)(A), because claimant was an "active participant" and the assault was not connected with his job assignment. We conclude that the claim is compensable, based on the following reasoning.

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.*

An injury occurs "in the course of" employment if it takes place within the period of employment, at a location where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it. *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 598 (1997). "In the course of" employment also includes a reasonable period of time after work for the worker to leave the employer's premises. *Id.*

Here, the insurer argues that the injury did not occur "in the course of" claimant's employment because it happened after the supervisor had told him to go home. But the blow was struck within a few minutes of those instructions and within minutes of 4:30 p.m., the regular end of claimant's work day. Even if claimant was technically "off the clock," because his supervisor had the authority to send him home before 4:30, we do not find a matter of minutes sufficient to sever the otherwise-established work relationship. In this regard, we note that the assault occurred on the work premises, probably at or before claimant's regular quitting time. We also find that a discussion, even an argument, about quitting time, which begins on the job site during work, is reasonably incidental to claimant's duties of employment. Accordingly, we conclude that claimant's injury arose "in the course of " his employment.

The "arising out of" employment element concerns the causal connection between the injury and the employment. *Fred Meyer, Inc. v. Hayes*, 325 Or at 596. In *Redman Industries, Inc. v. Lang*, 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 claimant's 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.[1] 326 Or at 39. The Court held that, in general, the risk of an assault by a co-employee in the workplace is a risk to which the work environment exposes an employee. *Id.* at 40. Nevertheless, the workplace assault by a co-employee must be caused by circumstances associated with the work environment. *Id.* In other words, if the motivation for an assault by a co-employee 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.*

The subject matter of this altercation is not disputed: Claimant and his supervisor were arguing about whether claimant should keep working until 4:30 p.m. when the supervisor struck claimant's face. There is no evidence that the disputants 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. Therefore, the claim is compensable unless it is statutorily excluded under ORS 656.005(7)(b)(A), which 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[.]"

The statute "excludes from compensability injuries from assaults (1) to an active participant in the assault *and* (2) when the assault is not connected to the job assignment and amounts to a deviation from customary duties." *Lang*, 326 Or at 38 (emphasis in original). Unless both of those elements are met, the exclusion does not apply. *Id.*

Where, as here, claimant has shown that his assault-related injuries arose out of and in the course of employment, the burden shifts to the carrier to prove that the exception in ORS 656.005(7)(b)(A) applies. *Donald Converse*, 50 Van Natta 1830, 1832 (1998). To defeat a finding of compensability, the employer must establish by a preponderance of the evidence that the 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. *Id.*

In *Converse*, the claim was compensable because the assault arose directly out of claimant's position and duties as a supervisor. Therefore, we reasoned that the assault was directly connected to the claimant's job assignment and the statutory exclusion did not apply.

This case is similar to *Converse*. There we said, for the "active participant" exclusion to apply, the assault must be "separate from, and not linked or joined with, the claimant's assigned duties." 50 Van Natta at 1833. This assault was linked with claimant's job duties because it grew out of a dispute whose subject matter was related directly to work -- whether claimant was to keep working past 4:00 p.m. that day. *See Lang* at 38, quoted in n. 1, *supra*. There is no contention that the motivation for this assault arose from an off-work relationship or for nonwork related reasons.

This case is also distinguishable from *Kessen v. Boise Cascade*, 71 Or App 545 (1984). The *Kessen* dispute arose between the claimant and his supervisor about whether the claimant would be allowed a certain night off work. But the *assault* occurred only after the claimant grabbed a co-worker's wrapped and bandaged arm, having first called the co-worker one of the "favored few." The co-worker then "nailed the claimant with a right to the jaw," causing the injury claimed. 71 Or App at 546. Although the original dispute concerned work-related matters between the claimant and his supervisor, the

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[1] In *Lang*, the parties agreed "that an injury caused by an assault in the workplace by a co-employee is compensable if the assault grew out of a quarrel whose subject matter is related *directly* to work." 326 Or at 38. And the Court said, "*We also agree that the legislature intended such injuries to be compensable.*" *Id.* (emphasis added).

claimant then physically engaged a third party, the co-worker, who caused his injury. In other words, the *Kessen* assault was perpetrated by a third person, not a party to the work-related argument.[2]

Here, we have determined that claimant's assault was, in fact, connected to his job assignment. We need not determine whether claimant was an "active participant" or the assault amounted to a deviation from his customary job duties, because even if these elements were satisfied, the statutory exclusion would not apply. *See* 326 Or at 38. Consequently, we find that claimant's assault-related injuries are not excluded under ORS 656.005(7)(b)(A). They remain compensable under ORS 656.005(7)(a).

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

ORDER

The ALJ's order dated November 13, 1997 is reversed. The insurer'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 $3,000 attorney fee to be paid by the insurer.

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[2] *See Converse*, 50 Van Natta at 1834, n. 6 (questioning whether the court's rationale --*i.e.*, that an assault would not be connected to the job assignment unless the job description entailed assaultive conduct--remains good law in light of subsequent cases).

Board Member Haynes specially concurring.

Under the doctrine of *stare decisis*, I am obligated to follow the majority's holding in *Donald Converse*, 50 Van Natta 1830 (1998). Nevertheless, I direct the parties' attention to my dissenting opinion in *Converse*.

October 29, 1998 Cite as 50 Van Natta 2119 (1998)

In the Matter of the Compensation of
EMILY G. McINTOSH, Claimant
WCB Case No. 97-07326
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's partial denial of claimant's injury claim for grade I L5-S1 spondylolisthesis, disk protrusion/bulging at L5-S1, bilateral L5 nerve root impingement and bilateral radicular pain. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 23, 1998 is affirmed.

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[1] Claimant also contends that the denial was an invalid preclosure denial. We do not address this issue because it was raised for the first time on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997) (Board's own decisions establish the rule that it will consider only issues raised at hearing). We also note that the parties agreed to litigate the merits of the denial at the outset of the hearing. (Tr. 4-5). *See Laura R. Frank*, 50 Van Natta 767, n. 1 (1998) (Where the parties agree to litigate the merits of the denial at hearing, denial's alleged procedural defect is waived and not addressed on review).

In the Matter of the Compensation of
PHIL E. MOREY, Claimant
WCB Case Nos. 97-08851 & 97-06058
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that dismissed his request for hearing as untimely filed. On review, the issue is the timeliness of claimant's request for hearing.

We adopt and affirm the ALJ's order with the following supplementation regarding the sufficiency of claimant's July 25, 1997 request for hearing.

Claimant's former attorney's request for hearing did not reference the self-insured employer's July 9, 1997 denial nor did it raise "compensability" as an issue. Instead, only penalty and attorney fees were designated as issues. Claimant's former attorney's cover letter likewise made no reference to any denial. The cover letter and request for hearing were received by the Board on July 28, 1997.

On August 2, 1997, a Notice of Hearing was mailed to claimant, claimant's former attorney's office, and the employer. On or about September 24, 1997, claimant's former attorney was advised by defense counsel that the original request for hearing possibly included a procedural defect. On October 20, 1997, claimant's former attorney filed a request for hearing that specifically appealed the July 9, 1997 denial.

Claimant has an obligation to request a hearing in response to each denied claim in order to place the denial before an ALJ. ORS 656.319(1); *Naught v. Gamble, Inc./Pepsi Cola, Inc.*, 87 Or App 145 (1987). In other words, a request for hearing must be referable to a particular denial. *Guerra v. SAIF*, 111 Or App 579, 584 (1992); *see Douglas D. LaGrave*, 47 Van Natta 2176 (1995) (where the insurer issued two denials on the same date, one denying a CTS claim and the other denying a right shoulder claim, and the claimant's request for hearing referred to the CTS claim denial but did not refer to the right shoulder claim denial, the Board found that the hearing request did not raise the issue of the right shoulder claim denial). The ALJ found that claimant failed to timely meet that obligation because claimant's original request for hearing did not identify the employer's denial as an issue. On review, claimant argues that his original request for hearing satisfied that obligation. In support of his argument, claimant cites *Victoria L. Springer*, 46 Van Natta 2419 (1994), and *Kevin C. O'Brien*, 44 Van Natta 2587 (1992). We find those cases distinguishable.

In *Springer*, the claimant's hearing request identified the insurer's denial as an issue. However, the hearing request mistakenly stated a denial date of August 19, 1993, rather than the correct date of August 23, 1993. We found that the hearing request was legally sufficient in that the August 23, 1993 denial was the only outstanding denial; therefore, we found the hearing request referable to the August 23, 1993 denial.

In *O'Brien*, two insurers denied responsibility for the claimant's current condition and, on August 5, 1991, a third insurer denied compensability and responsibility of the same condition. On August 15, 1991, the claimant filed an expedited hearing request with the Hearings Division and submitted an affidavit in support of that request. That affidavit stated, in part, that the third insurer had denied the claim based on compensability. We found that the claimant's affidavit and expedited hearing request, when read as a whole and in the context in which they were submitted, constituted an adequate request for hearing from the third insurer's August 5, 1991 denial.

Here, claimant argues that, applying the holdings in *Springer* and *O'Brien* and reading the record as a whole and in context, his original hearing request was sufficient to request a hearing from the employer's July 9, 1997 partial denial. We disagree.

In both *Springer* and *O'Brien*, the documents that were found sufficient to request a hearing actually raised the issue of the denials that were disputed in those cases. Although the documents' identification of those denials was not precise, it was sufficient enough to identify the denials that were at issue. *Compare Guerra v. SAIF*, 111 Or App at 583-84 (request for hearing on an insurer's failure to pay interim compensation benefits on a claim did not constitute a request for hearing on a separate insurer's denial of compensation on the same claim).

In contrast, here, the original hearing request upon which claimant relies did not raise the issue of compensability or identify the denial as an issue in any manner. To the contrary, the hearing request expressly designated penalties and attorney fees as the sole issues. On this record, we are unable to conclude that a hearing request that does not identify a denial in any manner in fact raises the issue of that denial.

ORDER

The ALJ's order dated January 16, 1998, as republished on April 13, 1998, is affirmed.

Board Member Biehl dissenting.

Because I would find that, reading the record as a whole and in context, claimant's original hearing request was sufficient to request a hearing from the employer's July 9, 1997 partial denial, I respectfully dissent.

To determine whether a hearing request is referable to a particular denial, we consider the request itself, read as a whole and in the context in which it was submitted. *See Kevin C. O'Brien*, 44 Van Natta 2587, 2588 (1992), *on recon*, 45 Van Natta 97 (1993).

In examining the context in which the July 25, 1997 hearing request was submitted, the following undisputed facts are decisive. First, claimant's July 25, 1997 request for hearing was filed by the 60th day after the mailing of the July 9, 1997 denial. Second, the July 9, 1997 denial was the only denial outstanding regarding this claim at the time of claimant's hearing request. Third, and most important, claimant's former attorney's uncontested affidavit establishes that the carrier understood that claimant's hearing request contested that July 9, 1997 denial.

In contrast to the majority, I find the present case analogous to our decision in *Kevin C. O'Brien*, 44 Van Natta at 2588-89. In *O'Brien*, three separate carriers issued denials. However, two of those carriers issued only responsibility denials and only one carrier, Aetna, issued a compensability and responsibility denial. We found that the claimant's affidavit and expedited hearing request, when read as a whole and in the context in which they were submitted, constituted an adequate request for hearing from Aetna's denial of compensability and responsibility. In this regard, the affidavit referenced the fact that all the carriers had denied responsibility but Aetna had also denied compensability. In addition, the affidavit was submitted as part of a request for an expedited hearing. Finally, although the affidavit failed to expressly request a hearing on Aetna's denial, we found that the claimant's intentions to do so were clear under the circumstances.

In the present case, the question of whether the denial was placed at issue is even more clear than it was in *O'Brien* because, here, there was only one claim, one denial, one employer, and one carrier (*i.e.*, the self-insured employer itself). Furthermore, the uncontested affidavit of claimant's former attorney establishes that the employer understood that claimant's July 25, 1997 hearing request raised the issue of compensability of the conditions denied by the July 9, 1997 denial. On this record as a whole, I would find that the July 25, 1997 hearing request is referable to the July 9, 1997 denial. Thus, I would find claimant's hearing request was timely and conferred jurisdiction with the Hearings Division. To hold otherwise places form over substance. After all, it is uncontested that the employer was aware that the July 9, 1997 denial was being contested.

Because the ALJ dismissed claimant's hearing request, no record was developed regarding the issue of compensability of claimant's preexisting degenerative disc disease and current condition. Therefore, I would remand the case to the ALJ for further development.

In the Matter of the Compensation of
GRANT W. TRACY, Claimant
WCB Case No. 97-02310
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

Claimant has an accepted 1990 claim for lumbar contusion and lumbar strain. He is attempting to prove an aggravation of that claim. The ALJ found that claimant did not prove an "actual worsening of the compensable condition." We agree with the ALJ and supplement to respond to claimant's arguments on review.

Claimant first asks that we vacate the ALJ's conclusion that "[n]o psychological condition is a compensable component of claimant's claim" because it may have a preclusive effect on any future psychological claim. Because no psychological claim was made or litigated at hearing, we understand the ALJ's statement as merely describing the 1990 claim. That is, the ALJ was only clarifying that the 1990 claim did not include a psychological condition and was not making any conclusions as to the compensability of any present psychological condition. Consequently, we find it unnecessary to "vacate" the ALJ's statement.

Claimant also goes to great length in discrediting a report from examining physicians Dr. Radecki and Dr. Dinneen. As explained below, because we agree with the ALJ that there is no persuasive evidence proving an "actual worsening of the compensable condition," claimant did not carry his burden of proof whether or not we consider Dr. Radecki and Dr. Dineen's report persuasive.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1); *Gloria T. Olson*, 47 Van Natta 2348 (1995). An aggravation has two components: causation and actual worsening. If the allegedly worsened condition is not already a compensable condition, compensability must first be established under ORS 656.005(7)(a). *Id.*

Claimant relies on the opinions of Dr. Kalbfleisch, claimant's previous treating physician, and Dr. Rust, claimant's current treating physician. According to Dr. Kalbfleisch, although claimant's condition apparently subjectively worsened, the worsening was "multi-factorial." (Ex. 137-26). In particular, although he thought that claimant experienced "real pain," Dr. Kalbfleisch also attributed claimant's symptoms to a psychological component. (*Id.* at 12, 27). Dr. Kalbfleisch was unable to apportion which of claimant's symptoms were caused by "real pain," as opposed to the somatic component. (*Id.*)

Because Dr. Kalbfleisch identifies a psychological component, we consider his opinion as showing that any worsened condition does not constitute solely the compensable condition. Furthermore, because Dr. Kalbfleisch did not indicate that claimant's current condition was in major part caused by the 1990 injury, we find his opinion insufficient to prove a compensable aggravation. *See Gloria T. Olson*, 47 Van Natta at 2348.

Dr. Rust did indicate that claimant's condition objectively worsened and that the worsening was in major part caused by claimant's 1990 injury. The ALJ, however, found Dr. Rust's opinion inadequate because he demonstrated little knowledge of claimant's medical history and he provided no reasoning to explain some parts of his opinion. We agree with the ALJ's analysis of Dr. Rust's opinion. We further note that Dr. Rust did not see claimant until September 1997, over two years after his symptom flare-up. Moreover, although acknowledging a psychological factor, he characterized it as only playing "some role," in contrast to the other physicians who identified significant psychological overlay. For this reason, we agree with the ALJ that Dr. Rust's opinion does not carry claimant's burden of proving a compensable aggravation.

ORDER

The ALJ's order dated June 11, 1998 is affirmed.

In the Matter of the Compensation of
DONNA A. GOODMAN-HERRON, Claimant
WCB Case No. 94-09926
ORDER ON REMAND
Daniel Snyder, Claimant Attorney
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Goodman-Herron v. SAIF*, 151 Or App 602 (1997). The court has reversed our prior order, *Donna Goodman-Herron*, 48 Van Natta 2434 (1996), that upheld the SAIF Corporation's denial of claimant's claim for a psychological disorder. In our prior order, we found that the case was governed by *Carr v. US West*, 98 Or App 30 (1989). Finding that the Oregon Supreme Court has since rejected the *Carr* analysis in *Redman Industries, Inc. v. Lang*, 326 Or 32 (1997), the court has reversed and remanded for reconsideration in light of *Lang*.[1]

We briefly recap the pertinent facts. In January 1994, claimant began working for the employer, with Hirsch acting as her supervisor. In March 1994, Hirsch, claimant and other coworkers traveled to Quantico, Virginia to meet with customers. Claimant's hotel room contained a computer, printer, paper and other materials used during meetings with customers. In the evenings, Hirsch and claimant would return to claimant's room and prepare presentations for the following day.

On March 8, 1994, following a business dinner, Hirsch and claimant returned to claimant's hotel room to prepare for meetings the next day. After finishing her work, claimant took some pain medication for her neck, later falling asleep while watching television. During this time, Hirsch continued to work in claimant's room. Later, claimant awoke to find Hirsch sexually assaulting her. Afterward, Hirsch convinced claimant that she would lose her job if she reported the incident. Claimant did not immediately contact the police or inform her employer.

Claimant continued to work for the employer, hoping to put the incident behind her. However, after returning from Virginia, Hirsch continually subjected claimant to sexual harassment, including unwanted physical touching. Claimant became increasingly despondent over the situation and, in April 1994, she reported the Quantico incident to two co-workers.

Shortly thereafter, the employer's upper management learned of the incident. In response, the employer assigned claimant a new supervisor and changed the location of her desk, moving it away from Hirsch. Hirsch continued to walk by claimant's desk on a daily basis, however. Claimant felt that this arrangement was unsatisfactory and voiced her concerns to the employer. The employer's executive vice president suggested that she quit if the changes were not acceptable.

On June 16, 1994, claimant felt unable to go to work and met with a psychiatrist. The psychiatrist found that claimant was having recurrent and distressing recollections of the sexual assault and harassment, including vivid nightmares of the event. The psychiatrist diagnosed claimant as suffering from Major Unipolar Depression, Single Episode, with some symptoms of Post-Traumatic Stress Syndrome (PTSS).

Claimant sought compensation benefits for her psychological injuries. SAIF denied her claim and she requested a hearing. Relying on *Carr v. U.S. West*, 98 Or App 30,[2] the ALJ held that, although

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[1] We granted SAIF's request for supplemental briefing on remand, and have received SAIF's brief and claimant's reply.

[2] In *Carr*, the worker was sexually harassed, assaulted and eventually raped by her supervisor while he accompanied her on outside sales calls. The court held that the worker's injuries were not covered by the workers' compensation laws because there was no evidence that the assaults and harassment were provoked by anything related to the work and because there was no evidence that the nature of the job environment created or enhanced the risk of assault. 98 Or App at 32-35.

claimant had established that she developed a mental disorder as a result of the sexual assault and subsequent harassment by Hirsch, her claim for the mental disorder was not compensable because her injuries did not "arise out of" her employment. On review, we affirmed, holding that *Carr* was binding precedent in this forum and that, in the absence of any evidence linking the assault to a risk connected with claimant's employment, her claim was not compensable.

As noted above, the court reversed and remanded for reconsideration in light of *Redman Industries, Inc. v. Lang*. There, the Supreme Court held that "[a]n injury arises out of employment if the risk of injury results from the nature of the claimant's work or from the work environment." The Court explained that, in the absence of evidence showing that motivation for a workplace assault was personal to the claimant, "the risk of an assault by a coemployee in the workplace is a risk to which the work environment exposes an employee." 326 Or at 40. The Court concluded that where there was no evidence that the claimant and his assailant had any relationship outside of work or that the motivation for the assault was fueled by an occurrence involving them outside of work, the claimant's assault-related injuries arose out of his employment. *Id.* at 41.

As an initial matter, in its supplemental brief on remand, SAIF urges us to reconsider our decision to adopt the ALJ's finding that Hirsch sexually assaulted claimant. While the court's reversal nullifies our prior order and allows us to reconsider findings of fact, *see, e.g., Bret Claussing*, 50 Van Natta 640, 641, n.4 (1998), we nevertheless adhere to our determination that the sexual assault occurred. Indeed, the ALJ made a specific finding, based on the documentary evidence, the substance of the witnesses' testimony *and* the demeanor and manner of the witnesses, that claimant's testimony concerning the sexual assault and subsequent sexual harassment was credible. After our *de novo* review of the record, we accept the ALJ's credibility finding, and conclude that the sexual assault and subsequent harassment did, in fact, occur. *See International Paper Co. v. McElroy*, 101 Or App 61, 64 (1990) (when the credibility determination is made on the basis of demeanor, deference is given to the ALJ's determination).

SAIF next contends that even if Hirsch sexually assaulted claimant, the assault and subsequent sexual harassment did not arise out of and in the course of her employment. Specifically, SAIF asserts that the assault did not occur "in the course of" employment because claimant had ceased working and was asleep when the assault occurred[3] and that it did not "arise out of" employment because it was not instigated by any stress or strain from the employment environment. As set forth below, we reject both contentions and conclude that claimant's claim is compensable.

The "in the course of employment" element concerns the time, place and circumstances of the injury. *See Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). Here, it is undisputed that claimant traveled to Quantico on business for the employer and that, while on this trip, her hotel room essentially served as a field office. A computer, printer and other materials were set up in the room, which claimant and Hirsch used in the evenings to prepare for the next day's presentations. Because claimant was on a several day, out-of town business trip, at the time of the assault, we find her to be a "traveling employee" at that time.[4] *See, e.g., Proctor v. SAIF*, 123 Or App 326 (1993). A "traveling employee" is continuously within the course and scope of employment while traveling, except when it is shown that the person has "engaged in a distinct departure on a personal errand." *Id.* at 330; *see also Savin Corp. v. McBride*, 134 Or App 321 (1995). Here, although claimant had ceased working and had fallen asleep at the time of the assault, she did not engage in any "distinct departure." To the contrary, she remained in her hotel room, watching television and dozing off while Hirsch continued to work in close proximity.

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[3] We note that, at hearing and on review, SAIF did not assert that claimant's assault did not occur in the course of employment. Rather, with regard to the work-connection test, SAIF argued only that claimant's claim did not "arise out of" her employment under the rule of *Carr*.

[4] On review, SAIF argued that, insofar as neither party specifically discussed claimant's status as a traveling employee at hearing, claimant did not timely raise the issue. We found that it was not necessary to determine whether the argument was timely raised, because even if the assault occurred in the course of employment, claimant's injury did not arise out of her employment under *Carr*. On reconsideration, since SAIF is not conceding that claimant's injuries occurred in the course of employment, we must consider whether claimant was, in fact, a traveling employee regardless of whether or not claimant specifically raised the application of the rule as an "issue" at the outset of hearing. *See, e.g., Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998) (Board must apply appropriate rule when the evidence supports its application irrespective of whether the claimant has uttered its name).

Under these circumstances, we conclude that the assault occurred in "the course of" claimant's employment.

The "arising out of" element tests the causal connection between the injury and employment. *Norpac Foods, Inc. v. Gilmore,* 318 Or at 366. As discussed above, an injury arises out of employment "if the risk of injury results from the nature of the claimant's work *or from the work environment.*" *Redman Industries, Inc. v. Lang,* 326 Or at 36 (emphasis added). The Court explained that this standard does not require that the motivation for the assault be a work-related matter. Rather, in general, the risk of an assault by a co-worker in the workplace is a risk to which the work environment exposes the employee. *Id.* at 40. The test is whether the workplace assault was caused by circumstances *associated with the work environment. Id.* (emphasis in original). In other words, unless the motivation for the assault is an event or circumstance pertaining to the claimant and the assailant that originated entirely separate from the workplace and the only workplace contribution was to provide a venue for the assault, the claimant's assault-related injuries will have arisen out of employment. *Id.*

Here, contrary to SAIF's contention, we are persuaded that Hirsch's sexual assault of claimant was caused by circumstances associated with the work environment. There is no evidence that claimant and Hirsch had any relationship outside of work or that the assault was fueled by an occurrence involving them outside of the work environment. Indeed, Hirsch's opportunity to sexually assault claimant was inextricably intertwined with her employment: The employer sent claimant and Hirsch on a business trip together. He had access to her hotel room for business-related reasons. The fact that the assault was not motivated by a specific work-related incident is not dispositive. After reviewing the evidence, we are persuaded that the events giving rise to the sexual assault occurred at the workplace (the makeshift office in claimant's hotel room) and that the sexual assault was caused by circumstances associated with the work environment. Consequently, the incident arose out of claimant's employment.

Finally, we adopt and affirm the ALJ's determination that claimant has proven by a preponderance of the evidence, particularly the well-reasoned opinion of Dr. Newton, that the sexual assault and subsequent harassment by Hirsch were the major contributing cause of a diagnosable mental or emotional disorder (major depression episode) which is generally recognized in the medical or psychological community. Claimant's claim is therefore compensable under ORS 656.802.[5]

Pursuant to ORS 656.386(1) and 656.388(1), claimant's attorney is entitled to an assessed fee for services at hearing, on Board and judicial review and on remand for finally prevailing over SAIF's denial on remand.[6] After considering the factors set forth 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 all levels is $75,000, payable by SAIF. The basis for this attorney fee award is set forth below. *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).

In his February 21, 1996 "post-hearing" statement of services, claimant's counsel requested a fee of $71,752.50 for services at and in preparation for hearing, based upon 459.1 hours of his time (at $150 an hour) and 38.5 hours of paralegal time (at $75 an hour). SAIF objected to this statement of services, asserting, among other things, that paralegal services are not recoverable, claimant's counsel's description of services are too vague and the time spent by claimant's counsel was excessive, as a significant portion of claimant's attorney's time was spent on issues collateral to the compensability dispute and therefore was unnecessary. In response to this last contention, claimant's counsel asserts that because SAIF pursued these collateral issues and matters in its defense of the denial, he was required to spend time preparing responses and rebuttals on these issues. We accept claimant's counsel's statement and, considering the issues in dispute, do not find the time spent at and in preparation for hearing excessive or unnecessary.[7]

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[5] Claimant has also shown that the conditions giving rise to her mental disorder (*i.e.*, the sexual assault and subsequent harassment) existed in a real and objective sense and that these conditions are not generally inherent in every workplace. *See* ORS 656.802(3)(a) - (d).

[6] Although claimant's counsel filed a brief in the Oregon Supreme Court in response to SAIF's petition for Supreme Court review (which was denied), he has withdrawn the request for attorney fees for these services. *See SAIF. v. Curry,* 297 Or 504 (1984) (ORS 656.382(2) authorizes attorney fee award when court actually allows an employer's petition for review).

[7] As SAIF notes, claimant's counsel is not entitled to recover paralegal time as part of his attorney fee, as such time is considered a cost. *See Candace L. Spears,* 47 Van Natta 2393, 2394 (1995).

Our review of the hearing record reveals that, although the primary issue in dispute was the compensability of claimant's psychological condition, a significant portion of the hearing testimony concerned the credibility, reliability and reputation of the two key witnesses, claimant and Hirsch. The hearing took 10 days, spread out over the course of seven months (December 1994 through early July 1995). In her case in chief, claimant presented 14 witnesses, including one medical expert. SAIF presented 19 witnesses in its defense, and claimant presented additional witnesses in her rebuttal. The transcript exceeds 2,100 pages. More than 80 exhibits were admitted and approximately 130 exhibits were initially submitted, including several by claimant. Claimant's counsel submitted a detailed, written closing argument, in excess of 80 pages in length. Moreover, prior to hearing, claimant moved to compel discovery of certain documents (including SAIF's investigation file), which required a telephone conference and resolution by an ALJ.

On Board review, claimant's counsel submitted a 25-page appellant's brief and an 11-page reply brief.[8] On judicial review, claimant's co-counsel submitted a 20-page petitioner's brief, with appendices, and presented oral argument. Furthermore, on remand, claimant's counsel submitted an 18-page brief in response to SAIF's brief regarding the course and scope of employment/compensability issue.

As compared to compensability disputes normally reviewed by this forum, the issues in this claim (particularly the credibility dispute, "course and scope" issue, and the existence and causation of claimant's psychological condition) were of a higher degree of complexity. The benefits secured are of average proportions, although claimant will likely receive compensation for medical services, temporary disability and, potentially, permanent disability for her compensable condition. As demonstrated by the extent of litigation as well as the legal and factual issues in dispute, there was a significant risk that claimant's counsel's efforts would go uncompensated. Finally, we note that claimant's counsel advocated claimant's claim in a professional manner through several levels of litigation in the face of a vigorous defense.

Considering the above, we find that claimant's counsel is entitled to an award of $75,000 for services at hearing, Board review, judicial review and remand.[9] We have taken into account the time devoted to the case at all levels (as represented by claimant's counsel's statements of services and SAIF's objections thereto, as well as claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. This attorney fee award does not include fees for services concerning issues of attorney fees, as claimant is not entitled to recover fees for such services. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986); *see also Amador Mendez*, 44 Van Natta 736 (1994) (claimant is not entitled to an attorney fee for her counsel's efforts in seeking an attorney fee).

Accordingly, on reconsideration, the ALJ's order dated April 19, 1996 is reversed. SAIF's denials of August 10, 1994 and December 6, 1994 are set aside and the claim is remanded to SAIF for processing according to law. In addition, claimant's counsel is awarded a reasonable attorney fee of $75,000 for services at hearing, on Board and judicial review and remand, payable by SAIF.

IT IS SO ORDERED.

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[8] Noting that claimant's counsel associated in co-counsel to assist with briefing on Board review, SAIF argues that the co-counsel's services (in preparing the reply brief) were duplicative and that at least half of his time should be disallowed. We disagree. We find that claimant's reply brief responds to arguments raised in SAIF's respondent's brief, and decline to find co-counsel's services duplicative, or the time spent unreasonable.

[9] This attorney fee award, which is payable to claimant's counsel-of-record, includes the fees for services rendered by co-counsel associated in by claimant's attorney on Board and judicial review. The manner in which the award is apportioned is a matter to be determined by them (claimant's counsel-of-record and co-counsel) and is not an issue for this forum. *See Gabriel Zapata*, 46 Van Natta 403 (1994).

In the Matter of the Compensation of
DENNIS J. NEELEY, Claimant
WCB Case No. 98-01979
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that found that claimant's concussion and cervical strain injury claim was not prematurely closed. On review, the issue is premature closure.

We adopt and affirm the ALJ's order with the following exception and supplementation. We do not adopt the last two sentences of the second paragraph of the ALJ's findings of fact. Nor do we adopt the third sentence of the next to the last paragraph of the ALJ's opinion. These sentences concern the ALJ's reading of several doctors' comments regarding compensability of claimant's fainting or syncopal episodes. Because the issue of compensability of the syncopal episodes was not before the ALJ, we make no findings or comment as to that issue.

On September 11, 1995, claimant was compensably injured in a motor vehicle accident (MVA). On September 14, 1995, claimant began treating with his family physician, Dr. Alanko, M.D., regarding the injuries sustained in the MVA. Dr. Alanko remained claimant's attending physician throughout his treatment for this work injury. (Exs. 4, 5, 8, 11, 13, 16, 25A, 30). On December 7, 1995, the insurer accepted "concussion and cervical strain" injuries. (Ex. 10).

On July 30, 1997, Drs. Wilson, examining neurologist, and Phillips, examining orthopedist, examined claimant, finding him medically stationary regarding the MVA and without permanent impairment. (Ex. 32-7). Dr. Alanko concurred. (Ex. 34).

On September 8, 1997, the insurer issued an "Updated Notice of Acceptance at Closure," listing the accepted conditions as "concussion and cervical strain." (Ex. 35). Claimant did not contest that Notice of Acceptance. On September 19, 1997, a Determination Order issued awarding temporary disability only. (Ex. 36). Claimant requested reconsideration and appointment of a medical arbiter.

Dr. Peterson, neurologist, served as medical arbiter and examined claimant on January 28, 1998. (Ex. 43). Dr. Peterson was instructed to report any objective permanent impairment resulting from the accepted conditions of concussion and cervical strain only. (Ex. 43-8, -10).

On February 11, 1998, an Order on Reconsideration issued that set aside the Determination Order as premature. This decision was based on Dr. Peterson's opinion and the fact that suggested testing regarding claimant's syncopal episodes had not been performed. (Ex. 44). The insurer requested a hearing.

The ALJ found that his sole focus in determining whether the claim had been prematurely closed was on the status of those conditions which had been accepted. We agree.

In *James L. Mack*, 50 Van Natta 338, 339 (1998), 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. In reaching this conclusion, we relied on the legislature's 1997 adoption of ORS 656.262(7)(c).[1]

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[1] In 1997, the legislature added ORS 656.262(7)(c), which provides:

"When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

Here, the only conditions accepted at the time of closure were the concussion and cervical strain conditions. (Exs. 10, 35). As the ALJ found, claimant did not contest the Notices of Acceptance, nor did he claim compensability of the syncopal episodes or any other condition. ORS 656.262(6)(d); 656.262(7)(a). Furthermore, Dr. Alanko, claimant's long-time treating physician, concurred with Drs. Wilson and Phillips that claimant was medically stationary. Only Dr. Peterson questioned claimant's medically stationary status. However, her concern was based on the possibility that claimant's syncopal episodes might be caused by traumatic epilepsy related to the compensable MVA. Nevertheless, because those conditions had not been accepted (or even claimed) at claim closure, their medically stationary status is not relevant to our current inquiry.

On review, claimant contends that his syncopal episodes are not a "condition," but are a symptom of an undiagnosed condition that may be a "direct medical sequela" of the accepted concussion condition. In support of this contention, claimant relies on ORS 656.268(16)[2] and asserts that diagnostic testing is compensable even if the diagnostic tests are only necessary to rule out the compensable concussion as a cause of the syncopal episodes. *Keith Faigen*, 50 Van Natta 17 (1998) (diagnostic tests compensable where necessary to determine the cause or extent of the compensable injury, whether or not the condition discovered as a result of the tests is compensable) (citing *Counts v. International Paper Co.*, 146 Or App 768 (1997)). We do not find claimant's argument persuasive.

First, by its terms, ORS 656.268(16) refers to rating permanent disability, not determining medical stationary status, which is defined under ORS 656.005(17).[3] Second, under the circumstances of this case, the issue of the compensability of the proposed diagnostic testing is neither before us, nor is it relevant to the issue of whether claimant's accepted concussion and cervical strain conditions are medically stationary. *James L. Mack*, 50 Van Natta at 339.

On this record, we agree with the ALJ that claimant has failed to prove that his claim was prematurely closed. Nevertheless, in making this finding, we note that claimant may challenge the Notices of Acceptance at any time and/or bring a "new medical condition" claim at any time. ORS 656.262(6)(d); 656.262(7)(a). If found compensable, the claim must be reopened for that new condition. ORS 656.262(7)(c); *Candice Marsden*, 50 Van Natta 1361 (1998); *Mario R. Castaneda*, 49 Van Natta 2135 (1997).

ORDER

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

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[2] ORS 656.268(16) provides:

"Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

[3] ORS 656.005(17) provides:

"'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

In the Matter of the Compensation of
SCOTT W. WHITE, Claimant
WCB Case No. C8-02316
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Biehl and Bock.

On October 21, 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 October 22, 1998, we received claimant's attorney's addendum to the CDA, which provides the parties' explanation regarding the calculation of the proceeds, including the potential impact of claimant's life expectancy and the possible effect of an offset for social security benefits in the event that claimant had received permanent total disability benefits. The accompanying cover letter provides that the insurer and insurer's counsel have been provided copies of the addendum. The insurer has raised no opposition to claimant's submission. We treat the parties' addendum as a motion for reconsideration of the approved CDA.

In order to be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received on October 22, 1998, within 10 days of the mailing of the order of approval, it is timely. OAR 438-009-0035(1). Thus, we grant the request for reconsideration.

We find that the agreement, as amended by the parties' addendum, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). We do not find any statutory basis for disapproving the agreement. *Id.* Accordingly, by this order, the CDA is approved, as amended by the parties' addendum.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
PEGGY L. STAMP, Claimant
Own Motion No. 98-0403M
OWN MOTION ORDER
Liberty NW Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable right carpal tunnel syndrome (CTS) claim. The insurer recommends that we authorize the payment of temporary disability compensation.

We begin with some background information. Initially, the record presented a discrepancy regarding under which claim own motion benefits were sought. After receiving clarification from the parties, we understand that claimant has at least two compensable claims with the insurer: (1) a right clavicle strain injury claim (Claim No. C604-347230); and (2) a right CTS condition claim (Claim No. C604-409722). The parties agree that the current claim involves the right CTS condition claim.

On November 5, 1993, claimant submitted an 801 form, making a claim for a right CTS condition and listing the date of injury as July 15, 1992. On November 24, 1993, the insurer issued a "Notice of Claim Acceptance" and accepted the claim as a nondisabling right CTS condition, with a date of injury of July 15, 1992. This notice further stated that any future aggravation claim "must be filed within five years after the date of injury." Finally, the insurer's acceptance provided that, "[a]lthough no formal closure of your claim for a nondisabling injury is required by law, this notice constitutes claim closure." Neither the insurer's acceptance nor its claim classification was contested by claimant.

On June 15, 1998, Dr. Bert, M.D., signed an aggravation notice form and released claimant to light duty from March 23, 1998 through the current date. On September 2, 1998, Dr. Freudenberg, claimant's treating physician, found that claimant's right CTS condition had worsened, related that condition to claimant's work, and recommended a carpal tunnel release. On September 25, 1998, the insurer submitted an own motion recommendation, recommending that we authorize reopening the claim for payment of temporary disability compensation.

Before addressing the insurer's recommendation, we must first resolve the question of whether claimant's claim is within the Board's own motion jurisdiction. *See Southwest Forest Industries v. Anders*, 299 Or 205 (1985) (a decision-making body may raise the issue of jurisdiction on its own motion); *SAIF v. Reddekopp*, 137 Or App 102, *rev den* 322 Or 360 (1995) (Board has authority to determine whether claim comes within its own motion jurisdiction).

The Board's own motion jurisdiction extends only to claims for which the claimant's aggravation rights have expired. ORS 656.278(1)(a); *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). A claim for aggravation must be filed within five years from the date of injury if the claim has been in *nondisabling status for one year or more after the date of injury.* ORS 656.273(4)(b). On the other hand, a claim for aggravation of a *disabling* injury must be made five years after the first claim closure made under ORS 656.268. ORS 656.273(4)(a).

The insurer contends that this "aggravation" claim was made after claimant's aggravation rights expired and is within the Board's own motion jurisdiction. Claimant disputes that contention and asserts that her claim should be processed as a compensable aggravation under ORS 656.273. Specifically, relying on the statement in the acceptance notice that the document also served as a claim closure, claimant argues that her aggravation rights expired on November 24, 1998, five years from the date of the November 24, 1993 acceptance notice. Thus, claimant argues, Dr. Bert's and Dr. Freudenberg's documentation, which issued before her aggravation rights expired on November 24, 1998, establishes that her current claim is a timely aggravation under ORS 656.273(4)(a). Therefore, under claimant's argument, the Board in its own motion authority does not have jurisdiction over claimant's claim. We disagree.

The insurer accepted claimant's right CTS claim as a nondisabling injury with a date of injury of July 15, 1992. Claimant does not dispute this. Nor does she contend that this "nondisabling" classification was appealed. To the contrary, claimant states that the acceptance notice "was never appealed, and the claim was heretofore nondisabling." Instead, claimant relies on a statement in the acceptance notice that that document also constituted claim closure to argue that ORS 656.273(4)(a) applies to her claim, with her aggravation rights running five years from the date of that "closure."

We find that claimant's reliance on that "closure" statement is misplaced. As noted in the insurer's claim acceptance notice, it was under no obligation to "close" a nondisabling claim. *See* ORS 656.268(2), (4). In any event, the "notice of acceptance" did not constitute a "notice of closure." In this regard, a "notice of closure" must comply with the requirements of ORS 656.268(4), including determination/evaluation of temporary and permanent disability and notice of claimant's right to request reconsideration of the closure. Here, the "notice of acceptance" did not include any of the requirements under ORS 656.268(4) for a "notice of closure." Thus, contrary to the insurer's statement, the "notice of acceptance" did not constitute a "closure" of the nondisabling claim. Instead, it was simply a claim acceptance.

Furthermore, aggravation rights for claims accepted as nondisabling (and remaining in nondisabling status for a year or more from the date of injury) run from the date of injury, *not* the date of claim acceptance. ORS 656.273(4)(b); *Larry C. Jacobs*, 48 Van Natta 2581, 2583 (1996). Because claimant's claim was in nondisabling status for a year or more after the date of injury, ORS 656.273(4)(b) applies to determine her aggravation rights. Thus, claimant's aggravation rights expired on July 15, 1997, or five years after the date of injury. Therefore, the "aggravation" claim made in 1998 by Drs. Bert and Freudenberg occurred after the expiration of claimant's aggravation rights. Inasmuch as claimant's aggravation rights have expired, the request for reopening falls under our own motion jurisdiction. ORS 656.278.

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

On September 2, 1998, Dr. Freudenberg recommended that claimant undergo a right hand carpal tunnel release. Thus, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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
MARSHA E. WESTENBERG, Claimant
WCB Case No. 97-05176
ORDER ON REVIEW (REMANDING)
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied claimant's motion to postpone the hearing; and (2) dismissed her request for hearing. On review, the issues are postponement and dismissal. We vacate and remand.

FINDINGS OF FACT

Based on the hearings transcript and written correspondence between the parties (contained in the hearings file), we make the following findings about pre-hearing and post-hearing events germane to the postponement and dismissal issues.

On March 7, 1998, claimant wrote a letter to the ALJ requesting postponement of the April 1, 1998 hearing. Her letter asserted that accommodation for her physical disability was unavailable on that date and stated that her reasons for needing a later hearing were beyond her control. Counsel for the employer responded by letter dated March 12, 1998, stating that "[w]ithout taking a position on the nature and extent of claimant's disability or the merits of the need for an accommodation we do not oppose this postponement request."

The ALJ responded by letter dated March 13, 1998. Finding no extraordinary circumstances beyond claimant's control, the ALJ declined to consider a postponement. The ALJ notified the parties that the hearing would convene on April 1, 1998 for the purpose of settling and completing the record.[1]

On March 14,1998, claimant wrote to the ALJ requesting that "this agency level proceeding be conducted in such a manner to help accommodate my nonfunctional hands." On March 18, 1998, the ALJ responded that claimant's request provided no explanation why the matter could not proceed as scheduled. Based on claimant's assertions, the ALJ again declined to grant a postponement of the April 1, 1998 hearing.

The ALJ convened the hearing on April 1, 1998. Claimant did not appear and no representative appeared on her behalf. The ALJ stated that the reasons given for claimant's postponement request "were inadequate for us to consider whether to postpone the case in accordance with ORS 656.283(4), which requires that. . . . a person requesting postponement show extraordinary circumstances beyond their [sic] control. The reasons given happen to be specifically prohibited by OAR 438-006-0081." (Tr. 1-2). Finding no circumstances justifying postponement, the ALJ concluded that he was required to dismiss the request for hearing as having been abandoned. (Tr. 3-4). The ALJ stated that he would issue an order to show cause.

That day, the ALJ issued an "Order to Show Cause," notifying claimant that the hearing had convened as scheduled and that claimant's request for hearing would be dismissed as abandoned, absent showing of extraordinary circumstances. *See* OAR 438-007-0071.[2] The order allowed claimant to respond no later than May 6, 1998.

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[1] The ALJ stated that the hearing would convene on April 1, 1998, unless the parties reached a stipulated agreement settling the record completely before that time. That did not happen.

[2] 438-006-0071 provides:

"(1) A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.

"(2) Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

On April 22, 1998, claimant responded that the April 1, 1998 hearing needed to be reset because of her disability, asserting that her hands "do not function." Specifically, she requested "accommodation in order to turn pages." She again requested a hearing date that would reasonably accommodate her disability.

On June 17, 1998, the ALJ issued an "Order of Dismissal." The ALJ noted that claimant's request for postponement had been denied for failure to state extraordinary circumstances beyond her control that would justify postponement. The ALJ also noted that the "Order to Show Cause" had issued and further observed that claimant had responded with reasons for requesting postponement which had already been rejected as inadequate. Specifically, the ALJ stated, "the mere fact that claimant's hands may be or are disabled does not explain why claimant could not attend the hearing." Order of Dismissal, p.1.

CONCLUSIONS OF LAW AND OPINION

The ALJ refused to grant claimant's motion to postpone the hearing because he found no extraordinary circumstances justifying postponement. When claimant failed to appear at the scheduled hearing, the ALJ dismissed her hearing request for the same reason.

OAR 438-006-0081 provides, in pertinent part:

> "A scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement."

Claimant first requested postponement on March 7, 1998, stating that accommodation for her physical disability would not be available at the April 1, 1998 hearing. The ALJ declined to consider her request, because he found no extraordinary circumstances justifying postponement. Claimant renewed her request and the ALJ denied it again before the hearing convened.

We acknowledge that claimant did not identify the specific accommodation she needed in initial postponement requests. However, her requests were timely and she asserted physical disability. Moreover, without taking a position regarding the nature and extent of claimant's need for accommodation, the employer did not oppose her postponement request. Under these circumstances, and particularly considering claimant's *pro se* status and the lack of opposition from the employer, we conclude that the ALJ should not have refused to *consider* postponement. On this basis, we conclude that claimant has established extraordinary circumstances under OAR 438-006-0081; the ALJ erred in denying postponement; and claimant's request for hearing should not have been dismissed. *See* OAR 438-006-0071(2). Accordingly, claimant's hearing request will be reinstated.

ORDER

The ALJ's order dated June 17, 1998 is vacated. Claimant's hearing request is reinstated. The matter is remanded to the Presiding ALJ for assignment to another ALJ, who will conduct further proceedings consistent with this order; *i.e.*, reschedule and convene a hearing regarding the issues arising from claimant's hearing request.[3] After these further proceedings, the assigned ALJ shall issue a final, appealable order.

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[3] We acknowledge claimant's concerns about the merits of her claim as well as alleged improper *ex parte* contacts between the employer's attorney and the ALJ. Claimant will have an opportunity to litigate the merits of her claim on remand. Her case will be assigned to a different ALJ on remand, to avoid even the appearance of impropriety regarding the alleged *ex parte* contacts.

In the Matter of the Compensation of
CARL C. GEIER, Claimant
Own Motion No. 98-0150M
OWN MOTION ORDER ON RECONSIDERATION
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our July 20, 1998 Own Motion Order in which we reopened claimant's claim for the payment of temporary disability compensation for his 1991 compensable fracture tip of right lateral malleolus. With its request for reconsideration, SAIF submitted a brief outlining its position and attached additional information regarding the work force issue.

In order to allow sufficient time to consider the motion for reconsideration, we abated our order, and requested that claimant respond to the motion. The parties' responses have been received. On reconsideration, we withdraw our prior order, and issue the following order in its place.

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).

We have previously found that the "time of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction, is the date of surgery or inpatient hospitalization.[1] *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Furthermore, the relevant time period for which claimant must establish he was in the work force is the time prior to when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App at 414; *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

SAIF contends that claimant fails to meet any of the criteria set forth in *Dawkins*. Claimant responds that, although he was not working at the time of his current worsening, he was willing to work and was seeking work within his limitations.

On reconsideration, both parties have submitted additional medical documentation and information regarding the history of the claim since August of 1996. We briefly review the history of the claim along with the additional documentation in an effort to fully address both parties' contentions.

Claimant last worked in August of 1996. He left work because of a re-injury to his right ankle. At the time, claimant was diagnosed with a right ankle strain and was placed in a brace. Claimant submitted a claim for aggravation for the August 1996 injury. SAIF denied the claim and that denial became final.

In March of 1997, claimant sought treatment for continued ankle pain with Dr. Neitling. Dr. Neitling opined that claimant's current condition was related to his compensable 1991 injury and recommended surgical excision of a fragment and debridement of the right ankle area. He also noted that claimant was capable of light duty work only, placing limitations on the amount of standing, walking and lifting claimant could perform. Dr. Neitling restricted claimant from any kneeling, squatting and getting into tight positions.

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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).

Thereafter, claimant's condition continued to deteriorate and in February of 1998, he sought treatment with Dr. Wisdom, who 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.

In May of 1998, Dr. Wisdom re-examined claimant and opined that claimant could not work effectively as a commercial fisherman due to his current condition. He also noted that after surgery it would be "8-12 weeks before [claimant] could get back to fairly heavy labor such as this." We interpret Dr. Wisdom's statement to indicate that claimant could return to his previous occupation should he undergo the required surgery.

Dr. Wisdom examined claimant on August 25, 1998. He continued to recommend surgical intervention. He also went into greater detail regarding claimant's ability to work. He stated:

> "In my opinion, the [claimant] is limited from this type of work, or in fact any similar work requiring long standing, walking, carrying weights, pushing loads, climbing ladders, gangways, or rigging, etc. He may not be totally disabled from the standpoint that he can perform sedentary work; that is, primarily a sit down job. He has no practical training, experience, or education to get such employment. Hopefully, if this surgery is successful, he can go back to commercial fishing, which he enjoys, and he is also readily employable. Otherwise, from my standpoint, I don't think he can work at this time."

Examining the first of the *Dawkins* criterion, we agree with SAIF that claimant was not working at the time of the current disability. He left work in August of 1996 and has not returned to the work force. Although claimant submits copies of paystubs, they all are dated in 1996. Therefore, those paystubs are not relevant to the questions before us -- whether claimant is in the work force at the "time of disability," *i.e.*, his current need for surgery, which first became evident in March of 1997, when Dr. Neitling recommended surgery.

SAIF contends that claimant has not satisfied the third *Dawkins* criterion because claimant has not demonstrated that he was willing to work and that it would have been futile for him to seek work. SAIF argues that none of claimant's physicians opined that claimant was unable to work in any capacity and, in fact, released him to light/sedentary work. We need not address SAIF's contentions regarding the third *Dawkins* criterion because, as discussed below, claimant has satisfied the standards set forth in the second *Dawkins* criterion.

In order to satisfy the second *Dawkins* criterion, claimant must show that, although he is not working, he is willing to work and was seeking work. SAIF argues that claimant has not demonstrated "willingness" because his work search involves attempts to find jobs which he is physically unable to do and thus is unreasonable. Claimant submitted two letters wherein he contended 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 asserted that he sought work on other people's boats and at other places of business throughout the area, but that "they are afraid I will get hurt worse and they will get stuck with the liability of my injury." Finally, claimant maintained 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 and do not find SAIF's argument to the contrary persuasive.

In response to SAIF's contentions, claimant submitted a letter wherein he outlines his current work search. Claimant attests that: "Besides all the fishing jobs I have [tried] to get, I have [applied] at [E]mpire Office Machines ***, and [R]ock and [R]oll [T]rucking. Also [, I applied] at my old job [A]storia [F]rozen [F]oods." Although most of claimant's efforts have been directed towards finding work on a fishing boat, claimant has tried unsuccessfully to get lighter duty jobs. Claimant's statement demonstrates that he has made a reasonable effort to seek work in a variety of fields. Finally, despite Dr. Wisdom's opinion that claimant is unable to work (given his lack of training, experience, or education, to get the sedentary work he is physically capable of performing), claimant has continued to seek work.

On this record, we conclude that claimant has established that he was willing to work and was making a reasonable effort to find work at the time of his current worsening.

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

IT IS SO ORDERED.

November 2, 1998 Cite as 50 Van Natta 2135 (1998)

In the Matter of the Compensation of
MARY ANN BORCHARDT, Claimant
WCB Case No. C8-02327
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Member Biehl and Bock.

On October 15, 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.

Paragraph 16, on page 4 of the CDA provides: "The parties agree that claimant became medically stationary on September 30, 1998, and the Employer/Insurer agrees to pay (in addition to the $20,000.00 sum due per this CDA) temporary total disability benefits to claimant through September 30, 1998."

We have held that it is impermissible for a CDA to accomplish claim processing functions, including claim closure, since it is not one of the objectives to be resolved with such an agreement. *E.g., Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992). In reaching this conclusion, we have reasoned that, by acting to close the claim, the CDA can affect the claimant's medically stationary status. Because a claimant's right to medical services is substantially limited on reaching medically stationary status, we are unwilling to approve an agreement which could be reasonably interpreted as a partial release of a claimant's statutory right to medical services. *Debbie K. Ziebert* at 51.

We do not interpret the present CDA, however, as attempting to impermissibly close the claim or establish the medically stationary date. Instead, because the CDA expressly provides that "[t]his claim has not been closed" and because the disposition fully releases claimant's rights to temporary disability benefits, we interpret the additional funds referred to in paragraph 16 on page 4 of the CDA not as additional "temporary total disability benefits," but merely as further consideration for the CDA, in addition to the $20,000 lump sum payment.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS J. BURNS, Claimant
WCB Case No. 98-00853
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) found that a stipulated settlement constituted an acceptance of a cervico-thoracic sprain/strain; (2) set aside the insurer's denial of that condition; and (3) found that the insurer's claims processing was unreasonable. Claimant cross-requests review of those portions of the ALJ's order that: (1) upheld the insurer's January 20, 1998 denial of claimant's current condition; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claims processing. Claimant also submits additional medical reports and requests remand to the ALJ for the taking of further evidence. On review, the issues are remand, the preclusive effect of a prior stipulation, compensability and penalties. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

In his brief on review, claimant includes additional medical reports and requests remand to the ALJ for the taking of further evidence. Claimant contends that the medical evidence concerns his disabling injury and was not available at the time of hearing.

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).

Claimant submits a report dated June 22 and 23, 1998 from Dr. Cook, a memo from claimant, a June 23, 1998 chart note from Dr. Cook and a June 22, 1998 nerve conduction test from Dr. Moravek. Claimant asserts that the evidence concerns his July 17, 1996 injury. He further contends that, due to the insurer's unreasonable claims processing, he was unable to obtain diagnostic medical services or a specialist's consult. After the hearing, however, he argues that he was able to obtain diagnostic studies and treatment from a specialist due to the intervention of a friend. The insurer opposes claimant's request, contending that these circumstances are insufficient to warrant remand.

Even if we assume that the proffered medical evidence was unobtainable with due diligence before the April 24, 1998 hearing, we are not persuaded the additional documents submitted by claimant are likely to affect the outcome of this case. We note that the record already contains medical evidence that claimant had some "cervical compromise" and radicular symptoms on the left arm in May 1997. (Exs. 28, 29). Consequently, we deny claimant's request for remand.

March 5, 1998 Stipulation

The ALJ determined that the parties' March 5, 1998 stipulation, in which the insurer agreed to rescind the August 21, 1996 denial and issue a Notice of Claim Acceptance, was ambiguous. The ALJ found that the insurer's August 21, 1996 denial was of a cervico-thoracic sprain/strain. Reasoning that there was no meeting of the minds expressing a clear intention of what conditions would be accepted, the ALJ construed the ambiguity against the insurer, who drafted the stipulation. The ALJ concluded that the stipulation constituted an acceptance of a cervico-thoracic sprain/strain and set aside the insurer's March 12, 1998 denial.

The insurer argues that the ALJ's interpretation of the stipulation was unreasonable and incorrect. The insurer contends that there is nothing ambiguous about the phrase "injury to the thoracic spine" in the stipulation. The insurer asserts that the ALJ erred by concluding that there were two separate injury conditions (a cervical strain and thoracic strain) when the medical reports indicated claimant had a single injury to the thoracic spine, with referred symptoms to the cervical spine.

The issue is whether, by entering the stipulation, the parties intended to resolve claimant's claim for a cervical strain. In construing this stipulation, we apply standard rules of contract construction. *Pollock v. Tri-Met, Inc.*, 144 Or App 431, 435 (1996). We construe the agreement to render, if possible, all of its provisions harmonious and to carry into effect the actual purpose and intent of the parties as derived from the terms of the agreement. *Id.* We must undertake to ascertain the intent of the parties at the time of their settlement. *Id.*

The Stipulation and Order approved on March 5, 1998 provided:

"IT IS HEREBY STIPULATED * * * that the claimant filed a claim for an injury to his thoracic spine occurring on or about July 14, 1996. The compensability of this claim was denied on August 21, 1996 and the claimant requested a hearing from this denial.

"IT IS FURTHER STIPULATED AND AGREED that the parties agreed to compromise and settle this matter, subject to the Workers' Compensation Board approving the following agreement of the parties:

"1. The employer/insurer hereby rescinds its denial and agrees to issue a Notice of Claim Acceptance; and

"2. The employer/insurer agrees to pay to the claimant's attorney the sum of $2,500 as a reasonable attorney's fee for his efforts in securing the rescission of the employer/insurer's denial.

"IT IS FURTHER STIPULATED AND AGREED that this settlement resolves all issues that have been or could have been resolved at this time.

"IT IS FURTHER STIPULATED AND AGREED that there has been no Claims Disposition Agreement filed with the Workers' Compensation Board in this matter.

"* * * * *

"THIS SETTLEMENT IS APPROVED AND THE CLAIMANT'S REQUEST FOR HEARING IS DISMISSED WITH PREJUDICE." (Ex. 42).

On January 20, 1998, the insurer accepted a thoracic strain resulting from claimant's July 14, 1996 work incident. (Exs. 38, 40). The parties' stipulation was approved on March 5, 1998. (Ex. 42). In the first paragraph of the stipulation, the parties agreed that claimant had filed a claim for "an injury to his thoracic spine occurring on or about July 14, 1996." (*Id.*) The stipulation further provided that the insurer had denied compensability of "this claim" on August 21, 1996 and claimant requested a hearing from "this denial." The language of the stipulation indicates that the insurer agreed to rescind a denial of an "injury to [claimant's] thoracic spine" and issue a Notice of Claim Acceptance. Thus, the stipulation indicates the insurer agreed to accept an "injury to [claimant's] thoracic spine." Nevertheless, because the insurer had already accepted a thoracic strain, we find that the stipulation must necessarily include something more than a thoracic strain. In other words, it would be unreasonable to construe the stipulation to mean that the insurer agreed to accept a thoracic strain, when it had already done so.

We examine the other terms of the stipulation to determine the scope of the insurer's acceptance. One of the later paragraphs in the stipulation purports to resolve all "issues"--not "claims"--that "have been or could have been resolved at this time[,]" *i.e.*, as of March 5, 1998. In the context of the entire agreement, "issues" refers necessarily to matters relating to the broader subject of the settlement. *See Liberty Northwest Ins. v. Bowen*, 152 Or App 549, 553 (1998). That subject could reasonably be described as either (a) claimant's injury--*i.e.*, the "injury to his thoracic spine," or (b) the July 14, 1996 work incident. *See id.* at 553-54. Because the paragraph is capable of more than one reasonable construction, this language is ambiguous. Therefore, we consider evidence as to the parties' subjective intentions and other circumstances surrounding the execution of a disputed provision. *See*

Williams v. Wise, 139 Or App 276, 281 (1996). We construe the provision in the light of that evidence, but in a manner that comports with the "objectively reasonable construction of the terms" to which the parties agreed. *Id.*

The insurer contends that the denial language and the settlement language referred to the entire claim exactly as it was being described in the contemporaneous medical reports. Based on the following reports, we conclude that claimant sustained a cervical sprain/strain resulting from the July 14, 1996 injury and that condition was resolved by the stipulation, whereby the insurer agreed to accept that condition.

Claimant signed an "801" form on July 29, 1996 that referred to a left upper thoracic strain. (Ex. 3). One day later, Dr. Dawson signed an "827" form that diagnosed acute severe post-traumatic cervico-thoracic sprain/strain. (Ex. 5).

The insurer's August 21, 1996 denial provided, in part:

> "You filed a claim for an industrial injury or occupational disease for *cervico-thoracic strain/sprain* allegedly sustained on or about 7/14/96 while you were employed with [the employer]. After reviewing information in your file, we find that we are unable to accept responsibility for any treatment and/or disability in connection with the above condition. Insufficient evidence exists to justify your contention that your condition is the result either of an injury or disease related to your employment with [the employer]." (Ex. 10; emphasis added).

Claimant requested a hearing from this denial.

The medical records issued before the insurer's August 21, 1996 denial referred to claimant's condition as a "thoracic sprain/strain" (Ex. 4), a cervico-thoracic sprain/strain (Ex. 5), and a trapezius muscle strain. (Ex. 9). After the August 21, 1996 denial, claimant began treating with Dr. McNulty, who initially diagnosed a thoracic strain. (Exs. 14, 15-2). On October 15, 1996, she diagnosed a cervical and thoracic strain. (Ex. 21). On May 9, 1997, Dr. McNulty reported that claimant had a thoracic strain and evidence of some cervical compromise. (Ex. 28). On May 30, 1997, she said claimant had back and neck pain, with radicular symptoms on the left. (Ex. 29).

Dr. Rosenbaum initially diagnosed a cervical and thoracic strain "by history." (Ex. 25-3). Similarly, Dr. Gripekoven initially diagnosed a cervical and thoracic sprain. (Ex. 30-4). In a later report, Dr. Rosenbaum had reviewed additional medical records from 1995 and he concluded that claimant's primary symptomatology related to the July 14, 1996 injury was in the thoracic region. (Ex. 31-1). He explained that the "cervical symptoms appeared primarily referred from the thoracic region with a prior history of cervical difficulty." (Ex. 31-1, -2). He concluded that the most appropriate diagnosis was a thoracic strain rather than cervical pathology. (Ex. 31-2). Dr. McNulty agreed with Dr. Rosenbaum's assessment that claimant had "primarily a thoracic strain injury rather than a cervical strain." (Ex. 33).

Dr. Gripekoven subsequently reported that claimant had sustained "soft tissue injuries of his thoracic spine and his cervical spine." (Ex. 34-1). He concluded that the soft tissue components of claimant's injury had resolved. (*Id.*)

After reviewing the additional evidence, we find that the portion of the stipulation that purports to resolve "all issues that have been or could have been resolved at this time[,]" does not reasonably describe only claimant's "injury to his thoracic spine." Rather, we find that the stipulation language was intended to describe "all issues that have been or could have been resolved" pertaining to the July 14, 1996 work incident. As we discussed earlier, because the insurer had already accepted a thoracic strain, the insurer's agreement in the stipulation to accept an "injury to [claimant's] thoracic spine" necessarily included something more than a thoracic strain. The preponderance of medical evidence, however, indicates that the only injury to claimant's *thoracic* spine was a thoracic sprain/strain. (Exs. 4, 5, 14, 15, 21, 25, 28, 30).

On the other hand, the medical evidence indicates that claimant also sustained a cervical injury as a result of the July 14, 1996 incident. Drs. Dawson, McNulty and Gripekoven diagnosed a cervical sprain/strain. (Exs. 5, 21, 30, 34, 35). Therefore, we conclude that the stipulation language that "resolves all issues that have been or could have been resolved at this time" describes all issues pertaining to the July 14, 1996 work incident. At the time of the March 5, 1998 stipulation, claimant's cervical sprain/strain condition had been identified and diagnosed.

After examining the additional evidence, including the contemporaneous medical reports, we find that a separate cervical condition resulting from the July 14, 1996 work incident had been identified at the time of the March 5, 1998 stipulation. The stipulation language that described "all issues that have been or could have been resolved" was intended to apply to all issues pertaining to the July 14, 1996 work incident. The insurer's August 21, 1996 denial referred to a "cervico-thoracic strain/sprain." (Ex. 10). In the stipulation, the insurer agreed to rescind that denial and issue a notice of claim acceptance. Under these circumstances, we conclude that the parties intended that the insurer would issue an acceptance that would include a cervical strain/sprain. Thus, we construe the March 5, 1998 stipulation to mean that the insurer accepted a cervical strain/sprain resulting from the July 14, 1996 injury. *Compare Jeffrey N. Davila*, 50 Van Natta 1687, *on recon* 50 Van Natta 1797 (1998) (because the herniated disc claim was not in existence at the time the parties agreed to settle and the carrier did not receive notice of the disc claim before approval of the written settlement, the disc claim was not precluded by the parties' stipulation).

March 12, 1998 Denial

After the insurer accepted a thoracic strain, claimant requested that the insurer modify its acceptance to include a cervical strain. (Ex. 44). On March 12, 1998, the insurer denied the cervical claim, explaining:

> "The preponderance of medical evidence indicates that the only industrial injury that you sustained is a thoracic strain. Any cervical symptoms that you may have experienced following your July 14, 1996 industrial injury were referred symptoms from your thoracic spine and treatment of your cervical symptoms were processed as part of your July 14, 1996 claim." (*Id.*)

In light of our conclusion that the terms of the March 5, 1998 stipulation included an acceptance of claimant's cervical strain/sprain, we set aside the insurer's March 12, 1998 denial.

January 20, 1998 Denial

On January 20, 1998, the insurer accepted a nondisabling thoracic strain resulting from the July 14, 1996 injury. (Ex. 38). On the same date, the insurer issued a denial of claimant's "current back condition." (Ex. 39). The insurer explained:

> "You filed a claim for a thoracic strain that combined with a pre-existing and non-industrial degenerative disc disease condition. As a result of your July 14, 1996 workers' compensation claim we have accepted a thoracic strain. The preponderance of medical evidence at this time indicates that your accepted thoracic strain is no longer the major contributing cause of your current back condition and need for treatment.
>
> "We therefore deny the compensability of your current back condition. Your thoracic strain has resolved and your impairment, disability and need for treatment is no longer compensably related to your industrial injury. Pursuant to OAR 436-030 we are notifying you that your claim qualifies for closure and we will be submitting your claim for closure." (*Id.*)

On the same date, the insurer issued an "updated notice of acceptance for closure" that identified the accepted condition as a disabling thoracic strain. (Ex. 40). The insurer also issued a Notice of Closure that did not award any permanent disability. (Ex. 41).

The ALJ analyzed the medical evidence and agreed with the insurer that the accepted conditions had resolved and claimant's residual problems were unrelated to the compensable injury. The ALJ upheld the insurer's January 20, 1998 denial.

On review, claimant argues that the insurer's January 20, 1998 "current condition" denial was a procedurally invalid precautionary denial because there was no acceptance of a combined condition. Claimant relies on *Vickie L. Davis*, 49 Van Natta 603 (1997), and *Robin W. Spivey*, 48 Van Natta 2363 (1996).

After the ALJ's order, we decided *Tracey A. Blamires*, 50 Van Natta 1793 (1998). *See also John K. Harkness*, 50 Van Natta 2055 (1998); *Jerry R. Baugh*, 50 Van Natta 2013 (1998). In that case, we disavowed *Spivey* and its progeny to the extent that those cases held that ORS 656.262(7)(b) applies only if the carrier has expressly accepted a combined condition. *Id.* at 1796. We concluded 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). *Id.* at 1794. In other words, 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. *Id.* at 1796.

In the present case, even if we assume, without deciding, that the insurer did not accept a combined condition, the medical evidence nevertheless establishes that claimant's accepted injury combined with a preexisting condition to cause or prolong disability or a need for treatment.

On November 19, 1997, Dr. Rosenbaum reported that he had reviewed additional medical records that indicated claimant was treated in 1995 for left shoulder and arm pain, left arm paresthesia and neck discomfort. (Ex. 31-1). He had also reviewed records indicating that claimant had a cervical fracture in the seventh grade with chronic apparent post-traumatic arthritis in the neck. (*Id.*) Dr. Rosenbaum concluded that the July 14, 1996 injury was most accurately diagnosed as a thoracic strain and claimant's cervical symptoms "appeared primarily referred from the thoracic region with a prior history of cervical difficulty." (Ex. 31-1, -2). We construe Dr. Rosenbaum's opinion to mean that claimant's preexisting cervical condition combined with the work injury. Dr. McNulty concurred with Dr. Rosenbaum's opinion. (Ex. 33).

Similarly, Dr. Gripekoven reported that claimant had sustained soft tissue injuries of his thoracic and cervical spine that combined with a preexisting condition. (Ex. 34-1). Dr. McNulty concurred with Dr. Gripekoven's opinion. (Ex. 35). Based on these medical opinions, we conclude that ORS 656.005(7)(a)(B) applies to this case.

On January 20, 1998, the insurer denied compensability of claimant's "current back condition" on the basis that the accepted thoracic strain was no longer the major contributing cause of his current back condition and need for treatment. (Ex. 39). The denial also notified claimant the insurer would be submitting the claim for closure. Thus, ORS 656.262(7)(b)[1] applies and we must examine the medical evidence to determine compensability of claimant's current condition.

Dr. Rosenbaum felt that claimant's decreased cervical range of motion was not due to the work injury, but rather was secondary to his previous cervical fracture and post-traumatic arthritis. (Ex. 31-2). Dr. McNulty concurred with Dr. Rosenbaum's opinion. (Ex. 33). Likewise, Dr. Gripekoven believed that the soft tissue components of claimant's injury had resolved and the major contributing cause of any residual impairment was related to the preexisting condition, a previous cervical fracture. (Ex. 34-2). Dr. McNulty concurred with Dr. Gripekoven's opinion. (Ex. 35).

After reviewing the medical evidence, we conclude that claimant's preexisting cervical condition is the major contributing cause of his current condition. Consequently, we uphold the insurer's January 20, 1998 partial denial.

For the following reasons, we are not persuaded by claimant's argument that the January 20, 1998 denial was procedurally invalid because it was issued the same date as the acceptance of a thoracic sprain/strain. Citing *Harry L. Lyda*, 48 Van Natta 1300 (1996), *aff'd State Farm Ins. Co. v. Lyda*, 150 Or App 554 (1997), claimant argues that there must be some sort of change in his condition or a change of circumstance such that the compensable injury is no longer the major contributing cause of his condition.

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[1] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

In *State Farm Ins. Co. v. Lyda,* 150 Or App at 558-59, the court interpreted ORS 656.262(6)(c).[2] In *Tracey A. Blamires,* 50 Van Natta at 1795 & n.4, we distinguished ORS 656.262(7)(b) from ORS 656.262(6)(c). We noted that ORS 656.262(7)(b) refers to the carrier's acceptance of a "claim," not to the acceptance of a "combined condition." *Id.* at 1795 n.4. We concluded that 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)" applies only when a carrier has *accepted* a combined condition. *Id.* In contrast, we reasoned 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. *Id.*

Here, in light of our determination that ORS 656.262(7)(b) applies to the insurer's January 20, 1998 denial, we need not decide if ORS 656.262(6)(c) also applies.[3] As we discussed in *Blamires,* the two statutory provisions are designed to address different situations.

Penalties

The ALJ found that the insurer's claims processing was unreasonable. Nevertheless, the ALJ did not award a penalty because there was no evidence there was any failure to pay compensation benefits.

The insurer contends that the ALJ erred in determining that its claims processing was unreasonable. On the other hand, claimant contends that the ALJ erred in not assessing a penalty.

We agree with the ALJ that there is no evidence of unpaid compensation. Therefore, we find no resistance to payment of compensation that would authorize the assessment of a penalty or a penalty-related attorney fee.[4] *See SAIF v. Condon,* 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson,* 108 Or App 253 (1991).

Claimant's attorney is entitled to an assessed fee for services on review concerning the March 12, 1998 denial issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the March 12, 1998 denial issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 16, 1998 is affirmed. For services on review concerning the March 12, 1998 denial, claimant's attorney is awarded $1,000, payable by the insurer.

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[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."

[3] We note, however, that claimant argues that the insurer did *not* accept a combined condition. If we accept claimant's assertion, ORS 656.262(6)(c) would not apply because that statute applies when a carrier has accepted a combined condition. *Blamires,* 50 Van Natta at 1795 n.4.

[4] Because of our conclusion that there is no evidence of unpaid compensation, we need not determine whether the insurer's conduct was unreasonable. Were we to address the issue, however, our analysis would be appropriately confined to the legal arguments raised by claimant (Tr. 2), and we would reject the ALJ's reasoning concerning an alleged "course of unreasonable claims processing" by the insurer.

In the Matter of the Compensation of
JUDITH L. HUNTER, Claimant
WCB Case No. 98-01403
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's claim for a cervical injury. On review, the issue is compensability.

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

SAIF argues that the ALJ erred in relying on the medical opinion of Dr. Copperman, claimant's treating physician, over the opinion of Dr. White, an examining physician. Specifically, SAIF argues that Dr. Copperman's opinion is unpersuasive because he relied on an inaccurate history that claimant had no symptoms prior to the work-related motor vehicle accident, changed his opinion without explanation and did not evaluate the relative contribution of the preexisting condition versus the injury in determining the major contributing cause of claimant's disability and need for treatment.

Based on this record, we are persuaded that Dr. Copperman, who had also treated claimant prior to and after her 1992 noncompensable neck surgery, was aware of the level of claimant's symptoms prior to the 1997 motor vehicle accident. In this regard, in a chart note dated over a month after the motor vehicle accident, Dr. Copperman noted that claimant had a "background of discomfort from underlying degenerative disk disease but this has been much worse over the past month." (Ex. 5-1). In addition, in his response to SAIF's claims adjuster's questions regarding claimant's condition, Dr. Copperman acknowledged claimant's significant preexisting spinal canal stenosis. (Ex. 7). In that same report, Dr. Copperman stated that claimant "had no symptoms prior" to the motor vehicle accident.

We conclude, however, based on Dr. Copperman's opinions and his familiarity with claimant's preexisting cervical condition, that Dr. Copperman meant that claimant had new and more severe symptoms after the motor vehicle accident that did not exist previously. We believe that the record supports the fact that Dr. Copperman was familiar with claimant's condition prior to and after the motor vehicle accident. Thus, we are not persuaded in the context of this record that Dr. Copperman possessed an inaccurate history.

SAIF also argues that Dr. Copperman "changed" his opinion regarding causation. In Exhibit 7, Dr. Copperman could not state "with any degree of medical certainty" whether the motor vehicle accident or the preexisting condition was the major contributing cause of the current condition and need for treatment. In a later opinion, Dr. Copperman agreed that it was more probable than not that the motor vehicle accident, as opposed to the preexisting condition, represented more than 51 percent of the cause of the combined condition, need for treatment and the disability. (Ex. 9).

We note that, in his first opinion in Exhibit 7, Dr. Copperman was addressing the causation question in terms of a "medical certainty," while in his later opinion, he was addressing a medical "probability." Thus, we do not find that it is necessarily inconsistent that he could answer the question to a probability and not to a certainty. Under the circumstances, we do not find that Dr. Copperman "changed" his opinion.

Finally, in response to SAIF's contention that Dr. Copperman did not weigh the contribution from the preexisting condition, we find that Dr. Copperman was aware that the legal issue was whether the major contributing cause of the disability and need for treatment of the combined condition was the work injury or the preexisting condition. His opinions regarding causation take into account the contribution from the preexisting cervical condition and conclude that the injury is the major contributing cause. (Ex. 9).

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

ORDER

The ALJ's order dated June 11, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

November 2, 1998 Cite as 50 Van Natta 2143 (1998)

In the Matter of the Compensation of
JOE G. CAPRON, Claimant
Own Motion No. 98-0111M
OWN MOTION ORDER DENYING RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 21, 1998 Own Motion Order, which denied his request for reopening of his 1990 injury claim for the payment of temporary disability benefits. We took this action because the dispute between the parties regarding the compensability of claimant's current condition remained unresolved.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. Claimant's request for reconsideration was received by the Board on October 22, 1998, more than 30 days after the issuance of our September 21, 1998 Own Motion Order. However, filing of a document other than a request for hearing or a request for review of an Administrative Law Judge's order or Director's order, may be accomplished by mailing within the prescribed time accompanied by an attorney's certificate that it was deposited on the stated date. OAR 438-005-0046(1)(c).

Here, claimant's request for reconsideration of our September 21, 1998 order was not mailed by certified mail, and was received by the Board on October 22, 1998. Claimant's request for reconsideration did not contain an attorney's certificate that the request was deposited in the mail on a stated dated. Therefore, in accordance with OAR 438-005-0046(1)(b) and (c), claimant's request was filed on October 22, 1998. Inasmuch as October 22, 1998 is more than 30 days after our September 21, 1998 order, the request was untimely filed. *See* OAR 438-005-0046(1)(b) and (c). Consequently, claimant's request for reconsideration is denied.

In any event, if we were to accept claimant's request for reconsideration as timely filed, he has not provided any new evidence or argument which would persuade us to reach a different conclusion. In other words, we have nothing further to add to the finding and reasoning set forth in our September 21, 1998 order.

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our prior orders nor extends the time for seeking review. *International Paper Company v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
GAIL J. KELLER, Claimant
WCB Case No. 97-08038
ORDER ON REVIEW
Jolles & Bernstein, Claimant Attorneys
Moscato & Hallock, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for right de Quervain's tendonitis and carpal tunnel syndrome (CTS). In its brief, the employer objects to the admission of Exhibits 16 and 17, medical evidence solicited by claimant. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

The employer objects to the ALJ's admission of Exhibits 16 and 17, reports from Dr. Canepa, claimant's hand surgeon, and Dr. Carlisle, claimant's family physician. The employer contends that this evidence is objectionable because the doctors' opinions regarding causation were inadequately supported by scientific principles, and, as such, violated the principle of "substantial justice" set forth in ORS 656.283(7).

We review the ALJ's evidentiary ruling for abuse of discretion. *See James D. Brusseau II*, 43 Van Natta 541 (1991).

In this case, we find no abuse of discretion. ORS 656.283(7) provides that the ALJ "is not bound by common law or statutory rules of evidence *** and may conduct the 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 (1981).

In this case, we find that the ALJ did not abuse her discretion in admitting Exhibits 16 and 17, for two reasons. First, the employer's attorney deposed both doctors subsequent to their reports. Nothing prevented the employer's attorney from requesting further explanation from either physician at that time. Second, insofar as the doctors' opinions are allegedly inadequately supported by scientific evidence, that evaluation goes to the weight accorded the evidence, not to its admissibility. Accordingly, the employer's motion to exclude Exhibits 16 and 17 is denied and we review the record as developed by the ALJ. *See* ORS 656.295(5).

Compensability

We adopt and affirm the ALJ's opinion on this issue with the following supplementation to address the employer's arguments on review.

The employer contends that ORS 656.802(2)(b) rather than 656.802(2)(a) is applicable in this case and that the ALJ, therefore, applied the wrong legal test to establish compensability. We disagree.

Although the medical evidence establishes that claimant had insulin-dependent diabetes and obesity that preexisted the development of her right de Quervain's tendonitis and CTS and that those preexisting conditions contributed to the development of her de Quervain's tendonitis and CTS, her claim is not based on the worsening of the preexisting diabetes or obesity. Rather, her claim is for the de Quervain's tendonitis and CTS conditions. Accordingly, we conclude that the ALJ properly applied ORS 656.802(2)(a), which requires that claimant must establish that her employment conditions, as opposed to the preexisting conditions, were the major contributing cause of her right de Quervain's tendonitis and CTS.

After our *de novo* review of the record, we agree with the ALJ's conclusion that claimant carried her burden to prove that her work activities were the major contributing cause of those conditions and her need for treatment of those conditions.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by 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 July 1, 1998 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,500, to be paid by the self-insured employer.

November 3, 1998 Cite as 50 Van Natta 2145 (1998)

In the Matter of the Compensation of
JAMES N. NAPPIER, JR., Claimant
WCB Case Nos. 97-08833 & 97-06089
ORDER ON REVIEW (REMANDING)
Linerud Law Firm, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; and (2) upheld SAIF's denial of claimant's claim for a new low back injury. In his reply brief, claimant seeks remand for admission of an MRI report and additional medical evidence concerning the MRI. On review, the issues are aggravation, compensability and remand. We vacate and remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denials of claimant's claim for a July 22, 1997 new low back injury. In addition, the ALJ upheld SAIF's denial of claimant's claim for an aggravation of the September 13, 1995 compensable injury. SAIF has acknowledged that claimant's current need for medical treatment is related to the accepted 1995 injury, but has denied that the injury has compensably worsened.

With his reply brief, claimant has submitted an MRI report which was dated after the hearing. We treat claimant's submission of the MRI report as a motion for remand to the ALJ for the taking of additional evidence. For the following reasons, we grant the motion for remand.

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we determine that the case was improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

According to the record, Dr. Gambee repeatedly requested an MRI in order to evaluate claimant's condition. In spite of this, an MRI was not performed until after the hearing. Dr. Bald also indicated that, in the absence of an MRI, he had no basis upon which to conclude whether claimant's compensable condition had pathologically worsened since the 1995 compensable injury. (Ex. 46-3). In upholding SAIF's denial of claimant's aggravation claim, the ALJ found the medical opinions of Drs. Bald and Gambee insufficient to establish compensability of an aggravation claim largely because they did not address the issue of whether there had been a pathological or "actual" worsening of claimant's condition.

Given the facts of this case, we find a compelling reason to remand. Without the MRI report, the record is incompletely developed. Despite claimant's physician's requests, an MRI was not authorized until after the date of hearing. On this basis, we conclude that the MRI was unobtainable with due diligence at the time of hearing. To the extent this "post-hearing" MRI report is pertinent to the nature and cause of claimant's current low back condition and is information the physicians believed was necessary in order to evaluate claimant's condition, we find that the evidence is reasonably likely to affect the outcome. *See Parmer v. Plaid Pantry # 54*, 76 Or App 405 (1985) (where proffered evidence regarding the claimant's post-hearing surgery "vindicated" the treating physician's prior opinion that the work injury was merely a possible cause of the claimant's need for treatment, the Board abused its discretion by not remanding the case to the ALJ); *see also Michelle T. Nagmay*, 47 Van Natta 1952 (1995) (case remanded for post-hearing surgery report).

Accordingly, we find that the case should be remanded to the ALJ for the taking of additional evidence, including the post-hearing MRI report proffered by claimant. In addition, the ALJ shall allow SAIF an opportunity to cross-examine the authors of the additional evidence and/or present rebuttal evidence. The ALJ shall conduct the further proceedings in any manner that will achieve substantial justice.

ORDER

The ALJ's order dated April 20, 1998 is vacated. This matter is remanded to ALJ Hoguet for further proceedings consistent with this order.

November 3, 1998 Cite as 50 Van Natta 2146 (1998)

In the Matter of the Compensation of
DOROTHY F. PETERSEN, Claimant
WCB Case Nos. 98-00448, 97-07480 & 97-09585
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Randy Rice, Defense Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

EBI Companies requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its compensability and responsibility denials of claimant's cervical disc herniation condition; (2) upheld the SAIF Corporation's responsibility denial of the same condition; and (3) awarded an assessed attorney fee of $12,000. In its brief, EBI also asks that we consider additional documents that it contends were inadvertently left out of the record. In her brief, claimant challenges that portion of the ALJ's order that found EBI's "back-up" denial of neck and thoracic strains was not procedurally invalid.[1] On review, the issues are compensability, responsibility, procedural validity of the "back-up" denial, and attorney fees. We affirm in part and modify in part.

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[1] Claimant also contends that the ALJ "correctly determined SAIF [sic] responsible for claimant's AC joint arthritis" and asks us to affirm that portion of the ALJ's order and award "appropriate attorney fees [] for defending against this issue on review." Neither SAIF nor EBI cross-requested review, or challenged in their briefs on review, this part of the ALJ's order. Consequently, we do not address that portion of the ALJ's order concerning the AC joint arthritis nor find any basis to award an assessed attorney fee for this issue. *See* ORS 656.382(2).

EBI asserts that, because claimant did not file a timely cross-request for review of any portion of the ALJ's order, we should not consider any issues raised by claimant on review that are not included in EBI's request for review. Based on our *de novo* review, we have authority to consider matters decided by the ALJ that are raised by the parties' briefs and in the absence of a formal cross-request for review, provided that the formal request for review has not been withdrawn. *E.g., Eder v. Pilcher Construction*, 89 Or App 425, 427 (1988). Here, because EBI did not withdraw its request for review and the ALJ decided the issues claimant challenges on review, we may consider claimant's arguments concerning these matters.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except we change the reference on page 4 from "May 16, 1997" to "May 14, 1997."

CONCLUSIONS OF LAW AND OPINION

Evidence/Compensability

EBI first contends that we should consider an office note from Dr. Newby, claimant's treating surgeon, and other documents. According to EBI, the documents were originally submitted to the ALJ for inclusion in the record but, because they were not provided to SAIF and SAIF produced the master exhibit list, the documents were not admitted into the record. SAIF objects to EBI's request.

We conclude that, whether or not we consider the additional documents, we agree with the ALJ that claimant proved the compensability of her cervical disc herniation condition. The opinion of claimant's treating surgeon, Dr. Newby, is unrebutted that a May 1997 injury while working for EBI's insured was the major contributing cause of claimant's herniated cervical disc. Although claimant's former treating surgeon, Dr. Jacobson, provided an opinion after Dr. Newby diagnosed the herniated cervical disc and he was aware of Dr. Newby's surgery directed to that condition, he did not address what caused the condition. (*See* Ex. 156).

Furthermore, we are not persuaded by EBI's argument that an office note from Dr. Newby (one of the documents that was not admitted at hearing) is "wholly inconsistent" with subsequent reports. The office note states that Dr. Newby thought that claimant's "initial complaints go back to the May 1995 injury as the cause of her need for [neck surgery]." We find the statement consistent with Dr. Newby's subsequent indication that "[a]ll incidents since 1985 have contributed to her current need for treatment," although the May 1997 injury was the major contributing cause. (Ex. 144).

Responsibility

In assigning responsibility to EBI for claimant's cervical disc herniation, the ALJ applied "actual causation" instead of the last injurious exposure rule.[2] Although asserting that the ALJ came to the right conclusion, claimant and SAIF contend that the last injurious exposure rule should decide the responsibility issue. Whether under "actual causation" or the last injurious exposure rule, we agree with the ALJ that EBI is responsible for claimant's cervical disc herniation condition.

In 1985, claimant injured her neck with an employer that was not part of this proceeding. In January 1993, while working for SAIF's insured as a bus driver, claimant sustained another neck injury; SAIF accepted a claim for "acute cervical and thoracic strain." In January 1996, claimant suffered an additional work injury that was accepted by EBI as a neck and thoracic sprain. In May 1997, while continuing to work for EBI's insured, claimant had the onset of neck symptoms after lifting a child.

Thus, this case concerns successive injuries with multiple insurers. Under such cases, the last injurious exposure rule imposes responsibility on the last employer that "contributed to the worker's" disability. *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 81 (1997). Because Dr. Newby indicated that the May 1997 injury (while EBI was the insurer) was the major contributing cause of the herniated cervical disc, we conclude that responsibility for the condition rests with EBI.

Procedural Validity of EBI's "Back-up" Denial

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

Attorney Fees

The ALJ awarded an assessed attorney fee of $12,000, to be paid by EBI, for overturning EBI's denial of compensability and responsibility for claimant's cervical condition. EBI asserts that the award is excessive because the case "involved relatively common medical and legal issues and only one prehearing deposition."

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[2] Because claimant's cervical disc condition has not been accepted by any insurer, the provisions of ORS 656.308 are not applicable. *SAIF v. Yokum*, 132 Or App 18 (1994).

We first acknowledge claimant's assertion that he should be awarded a fee under ORS 656.308(2)(d) for services concerning the responsibility issue.[3] We agree. Thus, we separately consider claimant's attorney fee for services at hearing with regard to compensability and the responsibility issues.

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, 157 exhibits were admitted at hearing. Claimant's attorney participated in a prehearing deposition that lasted one hour. The hearing lasted two hours; only claimant testified. Claimant's counsel submitted a statement of services attesting to 57.2 hours of time devoted to the case; the statement, however, does not distinguish between services devoted to the compensability issue as opposed to responsibility. At hearing, claimant's counsel also did not assert that the case involved extraordinary circumstances.

The complexity of the compensability issue was average. Although there were numerous exhibits and medical opinions, as discussed above, only one directly addressed the cause of claimant's cervical disc herniation; moreover, claimant's attorney generated only a few of the exhibits. All the attorneys were skillful in representing their clients and claimant's attorney secured valuable benefits for claimant, including compensation for surgery. Based on EBI's compensability defense to the claim, there was a risk that claimant's counsel might go uncompensated for services rendered.

Based on this review, especially the short length of the hearing, the limited number of relevant exhibits, and the average complexity of the compensability issue, we find that an appropriate fee for services at hearing regarding compensability is $6,000. Furthermore, for the same reasons, we find that claimant's attorney is entitled to $1,000, and not an extraordinary fee, for services at hearing concerning the responsibility issue.

Finally, claimant's attorney is entitled to an assessed fee for services on review for the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $750, payable by EBI. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review devoted to the responsibility, "back-up" denial, and attorney fee issues.

ORDER

The ALJ's order dated April 13, 1998 is affirmed in part and modified in part. That portion of the order awarding an assessed attorney fee of $12,000 is modified. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded assessed fees of $6,000 and $1,000, to be paid by EBI. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded a $750 attorney fee, to be paid by EBI.

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[3] In one part of the brief on review, claimant's attorney asks for a $1,000 fee and, in another part, requests an "extraordinary fee."

In the Matter of the Compensation of
ROQUE G. RODRIQUEZ, Claimant
WCB Case No. 97-05528
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's aggravation and current right shoulder condition claims. 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 "Conclusions of Law and Opinion" in the section entitled "Compensability and Aggravation," pages 10-11 of the Opinion and Order, with the following exception and supplementation.

We do not adopt the second sentence on page 11.

We acknowledge claimant's contention that the standard or proof for his bursitis/tendinitis claim should be "material cause." But claimant's preexisting noncompensable osteoarthritis contributes to his current condition, as does an inflammatory condition (bursitis/tendinitis/impingement syndrome) secondary to his work injury.[1] (*See* Ex. 44-32). Dr. Peterson anticipated repairing both problems at surgery. (Ex. 42). Therefore claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B). The question is: Do compensable causes contribute more to claimant's disability or need for treatment for the combined condition than all noncompensable causes combined? On this record, we conclude that they do not.

Before the surgery, Dr. Peterson opined that claimant's painful inflammation was more contributory than his hypertrophic acromioclavicular joint changes (and related impingement), based on the timing of the symptoms, MRI findings (that did not indicate significant *sub*acromioclavicular impingement), and claimant's response to injections (interpreted to indicate that the main problem was inflammatory). (Exs. 44-23-25, -27). But surgical findings included "rather severe degenerative changes at the acromioclavicular joint" and a "complete tear of the supraspinatus tendon." (Ex. 47-2). And Dr. Peterson performed a rotator cuff repair, as well as the anticipated subacromial decompression and distal clavicle resection. (Ex. 49). No medical evidence addresses the cause of the torn tendon discovered at surgery, the severity of the degeneration revealed and repaired, or the potential contribution by claimant's "anatomic Type II acromion." (*See* Ex. 42).

Under these circumstances, we cannot say that Dr. Peterson's "pre-surgery" opinions adequately evaluate the relative contributions of work and nonwork related causes. Moreover, Dr. Peterson's pre-surgery opinions are inconsistent with one another, with Dr. Peterson sometimes attributing major causation to claimant's subacromial bursitis and rotator cuff tendonitis and other times attributing major causation to claimant's preexisting degenerative condition. (Compare Ex. 37 with Ex. 42). Consequently, we conclude that the claim fails under ORS 656.005(7)(a)(B).

ORDER

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

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[1] It is undisputed that claimant's preexisting osteoarthritic degeneration contributes to his symptoms, disability, and need for surgery. (*See* Exs. 41-2, 41A-2, 42, 44-8-13, -18-19, -25, -35).

In the Matter of the Compensation of
GERALD SIKES, Claimant
WCB Case Nos. 97-08652 & 97-05867
ORDER ON RECONSIDERATION
Schneider & Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

On September 10, 1998, the Board issued an Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside TIG Insurance's denial of claimant's low back condition. Contending that claimant was not a credible witness or historian, and asserting that the medical evidence supporting his claim was conclusory and/or based on incomplete information, TIG sought reconsideration of the Board's decision and reversal of the ALJ's order.

In order to further consider the matter and to grant claimant an opportunity to respond, the Board's order was abated. Having now received claimant's response, we proceed with our reconsideration.

In its motion for reconsideration, the insurer argues that claimant is not credible. Specifically, the insurer argues that there is an "abundance of evidence" in the record which "casts doubt" on claimant's credibility.

Our Order on Review adopted the ALJ's Opinion and Order which found that, based on demeanor, claimant was a credible witness. We conclude that, if discrepancies in the record exist, they are minor ones which, in this case, do not outweigh the ALJ's demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61, 64 (1990). Accordingly, we do not reject claimant's testimony as requested by TIG.

TIG also argues that, regardless of whether claimant is credible, the medical evidence is not sufficient to find the claim compensable. TIG contends that Dr. Ordonez did not have a complete and accurate medical history from claimant. TIG also argues that Dr. Silver only indicated that he might change his mind regarding causation if claimant's history was reliable and it is not possible to say what conclusion Dr. Silver would actually reach.

We conclude that the medical evidence is sufficient to establish compensability. Although Dr. Ordonez' opinion supports claimant's case, the ALJ relied primarily on the opinion of Dr. Silver. After reviewing Dr. Silver's opinion, we agree with the ALJ's conclusion. Dr. Silver was aware of claimant's prior back problems at the time he provided his final opinion. Dr. Silver believed that the mechanism of the incident and the findings would be consistent with a disc. Ex. 52-9, 10. Consequently, Dr. Silver's only reluctance in finding a work connection was based on his concerns regarding claimant's credibility. Accordingly, we agree with the ALJ that, because claimant was a credible witness, Dr. Silver's testimony supports causation and claimant has established a compensable claim.

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

Accordingly, on reconsideration, as supplemented herein, we republish our September 10, 1998 Order on Review in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLELAND B. CARSON, SR., Claimant
WCB Case No. 97-03056
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's partial denial of claimant's claim for consequential amnesia and alcoholism conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusions of Law and Opinion," with the following modification.

On April 4, 1997, SAIF issued a partial denial of claimant's "amnesiac disorder and history of alcohol dependence (with current heavy drinking)." (Ex. 19).

The ALJ upheld the denial. We adopt the ALJ's opinion and conclusion on the merits of the amnesiac disorder claim.

Claimant argues that the ALJ erred in upholding SAIF's denial of alcohol dependence, contending that he filed no such claim and the denial of alcohol dependence is therefore null. We agree that the portion of the denial purporting to address alcohol dependence is a nullity.

Pursuant to ORS 656.262(7)(a), after claim acceptance, a worker must clearly request formal, written acceptance of any new condition. Absent such a claim by the worker, the carrier's denial is a nullity and has no legal effect. *See Stephenson v. Meyer*, 150 Or App 300 (1997); *Ramona E. Hamilton*, 48 Van Natta 2438 (1996), *aff'd mem* 151 Or App 266 (1997).

Here, claimant requested acceptance of his amnesia condition, nothing else. (Ex. 15). Because claimant never made a claim for alcohol dependence, SAIF's partial denial of that condition is "premature" and null. *See Ralph L. Morris*, 50 Van Natta 69, 71 (1998). We reverse the ALJ's order accordingly.

Claimant's attorney is not entitled to an assessed fee for services related to the portion of the denial that we set aside as a nullity. *See* ORS 656.386(1); *Stephenson*, 150 Or App at 300; *Gay Collins*, 49 Van Natta 1819 (1997).

ORDER

The ALJ's order dated June 30, 1998 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial of alcohol dependence is reversed to set aside that portion of the denial as premature. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ROBIN POTTER, Claimant
WCB Case No. 97-08463
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Craig A. Staples, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's occupational disease claim for left upper extremity condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In June 1997, claimant filed a claim and sought treatment for left arm and hand symptoms. The ALJ found that, based on claimant's treating physician, Dr. Ferguson, claimant proved that his work activities caused his left upper extremity condition. On review, the employer challenges that conclusion, asserting that Dr. Ferguson's opinion is not sufficiently persuasive to carry claimant's burden of proof. We agree with the employer.

The record contains two opinions concerning the cause of claimant's left upper extremity condition. Examining orthopedic surgeon, Dr. Bald, found it "very difficult, if not impossible, on the basis of the available medical records and physical examination to determine the exact nature of the claimant's current conditions." (Ex. 4-4). Dr. Bald's "clinical suspicion" was that claimant's symptoms were due to cervical disc disease and suggested that x-rays be taken to determine whether claimant had preexisting degenerative disease in the cervical and thoracic areas. (*Id.* at 5). Dr. Bald also indicated that, because claimant's mid-thoracic complaints arose at approximately the same time he went kayaking, he thought this condition was probably due to "non-work related activities." (*Id.*) According to Dr. Bald, "claimant's current conditions related to his left hand as well as to his mid-thoracic region are not specifically a result of either an acute, work-related injury or the cumulative nature of the claimant's work activities." (*Id.*)

When Dr. Ferguson saw claimant following his examination with Dr. Bald, Dr. Ferguson reported that he had indicated to claimant that he was "at a loss to explain what was going on." (Ex. 5A-1). Dr. Ferguson subsequently indicated that he concurred with Dr. Bald's report. (Ex. 6).

Dr. Ferguson then reported:

> "[Claimant's] work activity as a trim sill operator and grater [sic] was the major contributing cause of his condition, according to [claimant's] history. He had indicated that there was no outside work activity and it was only later that I became aware of his kayaking. So, at the time, my feeling was that this activity was indeed, according to what he had given me, the major contributing cause of his need for treatment and care." (Ex. 7-1).

Dr. Ferguson then stated that there was "really little disagreement between Dr. Ball [sic] and myself concerning the diagnoses." (*Id.*) Dr. Ferguson also found that, in the absence of x-rays, he was "not aware of any degenerative changes in the neck or pre-existing condition that [claimant] would have." (*Id.* at 1-2). Finally, Dr. Ferguson indicated that claimant's "work history was consistent with his injury" and he found no "significant disagreement between Dr. Ball [sic] and myself, probably raising different thought over seeing [claimant] in over two time frames, and I do not feel there was a significant preexisting condition, or at least am not aware of any." (*Id.* at 2).

We find that Dr. Ferguson's report is insufficient to prove compensability. In discussing causation, Dr. Ferguson premises his statement that claimant's work was the major contributing cause based only on the history claimant initially provided, which did not include kayaking activities. Dr. Ferguson does not expressly indicate that he continued to believe that work activities were the major contributing cause after learning of claimant's kayaking.

Furthermore, Dr. Ferguson had previously indicated that he was "at a loss" to explain claimant's condition and concurred with Dr. Bald's report. If Dr. Ferguson's final report can be interpreted as indicating that claimant's work is the major contributing cause, it does not explain why he previously was "at a loss" and agreed with Dr. Bald that claimant's work was not the major contributing cause. Instead, Dr. Ferguson continued to state that there was not "significant disagreement" between his and Dr. Bald's opinion.

In sum, for these reasons, Dr. Ferguson's opinion does not carry claimant's burden of proving that his work activities were the major contributing cause of his left upper extremity condition. *See* ORS 656.802(2).

ORDER

The ALJ's order dated June 24, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

November 5, 1998 Cite as 50 Van Natta 2153 (1998)

In the Matter of the Compensation of
KIMBERLY A. GOINS, Claimant
WCB Case No. 98-02074
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) awarded claimant an attorney fee under ORS 656.386(1) for her attorney's efforts in obtaining rescission of a denied claim before hearing; (2) awarded temporary disability benefits; (3) assessed penalties for the employer's alleged failure to timely pay temporary disability benefits; and (4) awarded a penalty-related attorney fee for allegedly unreasonable claims processing. On review, the issues are attorney fees, temporary disability, and penalties.

We adopt and affirm the ALJ's order with the following supplementation to address the employer's arguments regarding the ORS 656.386(1) attorney fee issue on review.

We briefly summarize the relevant facts. On September 9, 1997, claimant filed a claim for bilateral hand, wrist, elbow and shoulder pain. Claimant's condition was diagnosed as bilateral carpal tunnel syndrome (CTS) or bilateral tendinitis of the wrists and hands. She received treatment for her wrist conditions and copies of her medical reports were forwarded to the employer. The employer neither paid claimant's medical expenses nor responded to the claim.

Subsequently, the employer obtained medical reports that did not support a causal connection between claimant's work and her bilateral wrist condition. (Ex. 17, 22).

On March 10, 1998, claimant filed a hearing request, asserting a "de facto" denial of her claim and penalties and attorney fees.

On March 30, 1998, claimant sought treatment from Dr. Puziss, who diagnosed claimant's condition as overuse syndrome (tendonitis), which was causing CTS. Dr. Puziss authorized light duty work without any use of either hand from March 30, 1998 through June 30, 1998. There were no jobs available that claimant could perform with her restrictions, so claimant has not worked since that time. The employer has paid no temporary disability benefits.

On May 8, 1998, the employer filed its "Response to Request for Hearing." In that response, the employer checked the box on the form corresponding to the statement that the employer denies that claimant is entitled to a penalty/attorney fees. The employer also, in the space provided after "Other - Explain & Cite ORS:" wrote, "All issues raised or raisable by claimant."

On May 19, 1998, as amended on June 2, 1998, the employer accepted nondisabling bilateral wrist tendonitis.

On May 21, 1998, claimant amended her request for hearing to include "Failure to Timely Accept claim," and "Failure to pay TTD from 03-20-98 to present." The employer denied that claimant was entitled to TTD. The employer paid doctor bills on May 29, 1998. The hearing was held on June 5, 1998.

Reasoning that claimant's counsel was instrumental in obtaining rescission of a denied claim prior to hearing, the ALJ awarded claimant an attorney fee in the amount of $2,500. The insurer requested Board review, contending that claimant is not entitled to an attorney fee under ORS 656.386(1) because there was no "denied claim."

The ALJ found that the employer's conduct in obtaining a medical report that tended to refute a causal relationship between claimant's work activities and her bilateral wrist condition evidenced an effort to marshall evidence against compensability. The ALJ also found that the employer's failure to pay claimant's medical bills until after its acceptance, and the employer's failure to pay temporary disability after receiving Dr. Puziss' release to modified work that suggests that claimant was unable to work, was also evidence against compensability. Finally, the ALJ found that the employer's written statement in its response to claimant's hearing request, "All issues raised or raisable by claimant," indicated that the employer intended to deny all of the issues claimant had raised. The ALJ concluded that the insurer's conduct constituted a refusal to pay compensation on the express ground that the claimed condition was not compensable or otherwise did not give rise to an entitlement to compensation, consistent with the definition of a "denied claim" set forth in ORS 656.386(1). Finding that the employer had denied compensation, the ALJ awarded an attorney fee under ORS 656.386(1).

On review, the employer contends that inferences drawn from the employer's conduct are insufficient to meet the statutory requirements of ORS 656.386(1)(b)(A)[1]. In addition, the employer contends that, because it did not check the box stating that claimant was entitled to no relief, the ALJ had no grounds to find that the employer had *expressly* denied the claim. The employer cites *Galbraith v. L.A. Pottsratz*, 152 Or App 790 (1998) in support of its contentions. We disagree with the employer, based on the following reasoning.

While the employer may be correct in its assertion that its conduct alone cannot create a "denied claim" within the meaning of ORS 656.386(1), we need not reach that issue in this case. We agree with the employer that it did not check a box stating that claimant was entitled to no relief. Nevertheless, when the employer responded to claimant's hearing request regarding a "de facto" denial by writing under "Other," "All issues raised or raisable by claimant," in light of the insurer's other conduct evidencing a denied claim (as discussed by the ALJ), we agree with the ALJ's conclusion that the employer had expressly denied the claim.

Moreover, in its response, the employer wrote "*All issues raised or raisable by claimant.*" (Emphasis supplied.) The employer maintains on review that this language is "merely part of the employer's general form" and was not marked by the employer as an issue being denied in this case. We disagree because, to conclude otherwise, would elevate form over substance.

First, the hearing request and response forms serve the same function as pleadings in civil litigation. *See Freres Lumber Co. Inc. v. Murphy*, 101 Or App 92, *rev den* 310 Or 195 (1990). Claimant filed a request for hearing on the issue of a "de facto" denial and related penalties and attorney fees. Nothing in the record prior to the employer's response to claimant's hearing request indicates that the employer conceded compensability. Therefore, because the issues raised by claimant were a "de facto"

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[1] ORS 656.386(1) provides in pertinent part:

"(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[.]"

denial and related penalties and attorney fees, and the employer responded by denying the penalty and attorney fee issues and responded to the compensability issue by asserting "all issues raised * * * by claimant," we find that the insurer's assertions on the response to issues form challenge the compensability of the claim, as well as claimant's entitlement to compensation, and, as such, constitute an express denial of the compensability of the claim.

Claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In determining claimant's counsel's fee, we have not considered time devoted to the penalty and attorney fee issues. *See Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated June 22, 1998 is affirmed. For services on review, claimant is awarded a fee of $1,000, to be paid by the self-insured employer.

November 5, 1998 Cite as 50 Van Natta 2155 (1998)

In the Matter of the Compensation of
LINDA M. GROVER, Claimant
WCB Case No. 97-09184
ORDER ON REVIEW
Silven, Schmeits & Vaughan, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its "pre-closure" partial denial of claimant's current low back condition; and (2) awarded claimant's attorney a $3,500 assessed fee. On review, the issues are claims processing, compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and briefly summarize and supplement the pertinent facts as follows.

Claimant is a 41 year old food service worker who injured her low back while working for SAIF's insured on February 23, 1997. Claimant has a preexisting low back condition, including a mild, diffuse posterior disc bulge at L4-5, mild lower lumbar degenerative spondylosis, and moderate lower lumbar degenerative facet osteoarthrosis. Following the February 1997 injury, claimant experienced significant low back muscle spasm and pain radiating into the right leg.

SAIF accepted claimant's injury as a lumbosacral strain and then issued an October 6, 1997 pre-closure denial of claimant's current low back condition on the ground that: (1) claimant's preexisting lumbosacral degenerative joint disease, L4-5 disc bulge and/or psychological condition had combined with claimant's otherwise compensable injury to cause or prolong disability or a need for treatment; and (2) the otherwise compensable injury was no longer the major contributing cause of the combined condition and of the need for treatment of the combined condition. On October 8, 1997, SAIF issued an updated notice of acceptance stating that "[t]he accepted condition(s) for your February 23, 1997 injury include: LUMBOSACRAL STRAIN and current condition denial."

FINDINGS OF ULTIMATE FACT

Claimant's compensable low back injury combined with her preexisting low back condition.

Claimant's compensable injury is no longer the major contributing cause of her need for medical treatment or disability for her current low back condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that SAIF's "pre-closure" current condition denial was procedurally invalid under ORS 656.262(7)(b), which provides in pertinent part:

> "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

In concluding that SAIF's denial was procedurally invalid, the ALJ relied on *Donna Babcock*, 49 Van Natta 3083 (1997). We concluded in *Babcock* that, absent an acceptance of a combined condition, a carrier did not have authority under ORS 656.262(7)(b) to issue a "pre-closure" denial on the ground that an otherwise compensable injury was no longer the major contributing cause of the claimant's current combined condition. *See also Elaine M. Borgelt*, 50 Van Natta 143 (1998); *Robin W. Spivey*, 48 Van Natta 2363 (1996).

On review, SAIF challenges the Board's rationale in *Babcock* and argues that its denial was not procedurally invalid simply because it did not accept a combined condition. SAIF contends that its denial is authorized under ORS 656.262(7)(b) because the medical evidence establishes that claimant's compensable injury combined with her preexisting condition(s).

Subsequent to the ALJ's order, in *Tracy A. Blamires*, 50 Van Natta 1793 (1998), we disavowed *Babcock* and other prior Board cases holding that a carrier must accept a combined condition before availing itself of the pre-closure denial procedure under ORS 656.262(7)(b). *See also Jerry R. Baugh*, 50 Van Natta 2013 (1998); *John K. Harkness*, 50 Van Natta 2055 (1998). In so doing, we reasoned that ORS 656.262(7)(b) is applicable when the medical evidence developed subsequent to an acceptance discloses that the compensable injury either combined at the outset, or subsequently combined, with a preexisting condition.

Accordingly, SAIF's denial in the present case is procedurally proper if the medical evidence establishes that claimant's low back injury combined with her preexisting condition(s). The resolution of this 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 relevant opinions from Drs. Sanderfur, Jessen and McCormack.

Dr. Sanderfur, claimant's current treating orthopedist, opined that the February 1997 injury most likely aggravated claimant's preexisting degenerative disc disease and mechanical low back pain, but was no longer the major contributing cause of her present condition and disability. (Ex. 51). SAIF's medical examiners, Drs. Jessen and McCormack, were unable to determine whether claimant's February 1997 injury combined with her preexisting condition(s). However, assuming such a combined condition, they opined that the injury stopped being the major contributing cause within six to eight weeks of the injury. (Ex. 50).

We find no persuasive reason not to defer to the unrebutted opinion of Dr. Sanderfur that claimant's injury combined with her preexisting low back condition. Consequently, we conclude that SAIF's denial was procedurally valid, and we reverse the ALJ's contrary ruling.[1]

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[1] In light of our decision that the medical evidence establishes a combined condition, we need not address the employer's alternative argument that, assuming there is no combined condition, its denial is valid because the medical evidence establishes that claimant's current condition is totally unrelated to the compensable injury.

We turn to the substantive validity of SAIF's denial.[2] We defer to the unrebutted opinion of Drs. Sanderfur, Jessen and McCormack that the February 1997 injury is no longer the major contributing cause of claimant's current condition. Based on these opinions, we uphold SAIF's current condition denial.

Finally, in light of our decision to uphold SAIF's denial, claimant is not entitled to the $3,500 assessed attorney fee awarded by the ALJ.[3]

ORDER

The ALJ's order dated June 10, 1998 is reversed. The SAIF Corporation's October 6, 197 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] We decline SAIF's motion for remand to the ALJ for a ruling on the substantive validity of SAIF's denial. Pursuant to 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). As discussed above, the present record includes relevant causation opinions; and the parties agreed at hearing that the record was fully developed in this regard. (Tr. 6). Accordingly, we decline to remand this case to the ALJ, and we address the merits of SAIF's denial pursuant to our authority under ORS 656.295(6) to supplement or modify the ALJ's findings and conclusions.

[3] Consequently, we need not address SAIF's argument that the $3,500 assessed fee is not authorized under ORS 656.386(1) because: (1) claimant did not "finally prevail" on the merits of the compensability issue; and/or (2) SAIF's denial was premature.

November 5, 1998 Cite as 50 Van Natta 2157 (1998)

In the Matter of the Compensation of
GLEN A. HARBISON, Claimant
WCB Case No. 97-09517
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal order.

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

A hearing was scheduled for February 18, 1998. The ALJ postponed the hearing so that claimant could retain an attorney. The ALJ wrote to claimant on January 29, 1998 confirming that the hearing had been postponed and indicating that claimant should advise the ALJ within 30 days of the identity of his attorney.

On April 1, 1998, the insurer's counsel moved for dismissal for abandonment of the claim. The ALJ wrote claimant on April 10, 1998 and asked claimant to respond to the insurer's motion by explaining what he had done since January 29, 1998 to retain an attorney and why the case should not be dismissed for abandonment of the claim. Claimant responded to the ALJ's letter by explaining that he had been busy with business in Washington state, moving, doing his taxes and had a bout of flu, and that the date had slipped his mind. The insurer again requested dismissal pursuant to OAR 438-006-0071(1),[1] arguing that claimant had engaged in conduct that had resulted in an unjustified delay in the hearing of more than 60 days.

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[1] OAR 438-006-0071(1) provides: "(1) A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing *or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.* (Emphasis added).

On May 8, 1998, the ALJ granted the insurer's motion for dismissal noting that claimant's response gave no indication that claimant had even attempted to retain an attorney. On this basis, the ALJ found that claimant engaged in conduct resulting in an unjustified delay in the hearing of more than 60 days.

In his brief to the Board, claimant explained why he was unable to retain an attorney on Board review, but did not explain why he had not retained an attorney between the ALJ's January 29, 1998 letter to claimant and the ALJ's May 8, 1998 dismissal order. Although claimant's reply brief indicates that he believed that he had until May 1, 1998 to get an attorney, the ALJ's January 29, 1998 letter clearly states that claimant had 30 days from the date of the letter to advise the ALJ of the identity of his attorney. Thus, we find that claimant has given no justification for his delay in retaining an attorney in compliance with the ALJ's January 29, 1998 letter. Under such circumstances, we affirm the ALJ's dismissal order finding that claimant engaged in conduct that resulted in an unjustified delay in the hearing of more than 60 days.[2]

ORDER

The ALJ's order dated May 8, 1998 is affirmed.

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[2] We have generally interpreted a claimant's "post-hearing" correspondence after a hearing request has been dismissed for failure to appear as a motion for postponement of the scheduled hearing. In those cases, where the ALJ did not have an opportunity to rule on the motion, we have remanded to the ALJ for consideration of the motion. *See Randy L. Nott*, 48 Van Natta 1 (1996); *Olga G. Semeniuk*, 46 Van Natta 152(1994).

Here, unlike in other cases where we have remanded to ALJs to rule on a "post-dismissal order" request for postponement, claimant has not offered any reason not provided to the ALJ for his failure to retain an attorney in the time period provided by the ALJ's January 29, 1998 letter. Under these circumstances, we find no compelling reason to remand to the ALJ for further proceedings. *See Shirley J. Cooper*, 49 Van Natta 259, n 2 (1997).

In the Matter of the Compensation of
ERIC G. KOELLNER, Claimant
WCB Case No. 97-08133
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's injury or occupational disease claim for a toxic exposure-related condition; and (2) did not address its contention that the claim is precluded by a prior denial. In its brief, SAIF also objects to the ALJ's refusal to admit proposed Exhibits 2-8. On review, the issues are evidence, claim preclusion, and compensability. We affirm.

FINDINGS OF FACT

Claimant works for the employer as a hazardous materials technician, or "haz-cat." He receives household and commercial hazardous materials from the public that have been transported to the hazardous waste facility in private vehicles. His work involves receiving and handling thousands of hazardous chemicals, including solvents, pesticides, insecticides, rodenticides, anti-freeze, oil and water-based paints, and methylene chloride parts cleaners.

Fifty to eighty customers per day pull vehicles up to the receiving area at the employer's hazardous waste facility. Claimant and his co-workers unload the waste from the vehicles. Many customers bring uncovered wastes to the facility, such as unsealed pesticides and uncovered paint. Customers usually do not know or remember the chemicals that they bring to the facility for disposal. Often they transport chemicals in leaking containers or the materials have spilled in the vehicle by the time they arrive. Workers usually do not know what hazardous materials they will encounter when they open a customer's automobile trunk.

The employer requires workers to carry "half-face" filter respirator masks on their persons at all times, but its policy is to encourage wearing the masks only when workers "detect" a hazard. Workers do not wear masks or protective clothing when receiving wastes, to avoid alarming the public and to allow communication. Workers try to "mask up" when they feel that they need protection.

After receiving the materials from customers, claimant and his co-workers sort and "lab-pack" the chemicals in appropriate disposable containers. They wear masks for "lab-packing" and use "supplied air" for "bulking" oil-based paints.

Claimant believed that he was exposed to solvent or thinner fumes several times in late 1996 and thereafter. On these occasions, he experienced burning in his nose and at the base of his nose three to five minutes after he opened a customer's trunk. His upper lip turned red and felt raw. Sometimes he developed a rash and blotches of reddening that extended down the side of his mouth. The inside of his nostrils "felt like hamburger," bled, and developed scabs within a day. These symptoms lasted for a couple days. Claimant experienced these symptoms once or twice a month.

On later occasions, claimant's symptoms included a runny nose, eye watering and throat soreness. A day or two later, claimant's voice became hoarse. He eventually sought treatment from Dr. Peck, family physician, for chronic recurring hoarseness. Dr. Peck referred claimant to Dr. Dowsett, ear, nose, and throat specialist, when antibiotic treatment for a suspected viral condition was ineffective.

In April 1997, Dr. Flaming performed a surgical procedure to inspect claimant's larynx.

Claimant filed a claim for solvent exposure-related chronic hoarseness in July 1997. SAIF denied the claim in August 1997.

Dr. Burton examined claimant at SAIF's request, in September 1997.

Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

SAIF argues that the claim is precluded, based on a prior unappealed denial. SAIF also contends that the ALJ erred in refusing to admit proposed Exhibits 2-8,[1] offered to prove claim preclusion. The ALJ excluded these exhibits without receiving a prior objection from either party.

We find that the claim would not be precluded even if the proposed evidence was admitted. This claim is based on toxic exposure that occurred during and after 1996. (*See* Tr. 34). It is based on operative facts that did not exist as of the 1995 denial and there was no opportunity to litigate this claim in 1995. Accordingly, the claim is not precluded and the excluded evidence would not affect the outcome of the case. Under these circumstances, we find that the record is adequately developed without proposed Exhibits 2-8. Consequently, we need not determine whether the ALJ abused his discretion in refusing to admit exhibits to which neither party had objected.

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[1] Proposed Exhibits 2-8 are: June 22, 1995 chart notes and an "827" form signed by Dr. Miller; a June 23, 1995 x-ray report; a June 24, 1995 "Report of occupational injury or disease"; a June 29, 1995 chart note by Dr. Miller; a September 14, 1995 report by Dr. Burton; and a September 18, 1995 claim denial. We consider the proposed evidence only to determine whether the record is inadequately developed without it.

Compensability

The ALJ found claimant's occupational disease claim compensable, based on the "whole record," with particular reliance on *Liberty Northwest Ins. Corp. v. Cross.*[2] We reach the same result, for the following reasons.

It is undisputed that claimant's work involved handling hazardous materials, he was exposed to these materials at work (but not exposed to them off-work), and his work exposure *at least* caused physical irritation. The question is whether the medical evidence is sufficient to establish an occupational disease. *See* ORS 656.802(2).

SAIF argues that Dr. Burton's opinion is more persuasive than Dr. Dowsett's opinion. We disagree.

Dr. Burton opined that claimant's hoarseness, in particular, was unrelated to his work exposure. But Dr. Burton's conclusions are based on a materially inaccurate history concerning claimant's work activities and conditions.

The major premise of Dr. Burton's reasoning is that claimant suffered nothing more than a "negligible" exposure to hazardous materials at work. (Tr. 67-68, 71). This belief is apparently based on a mistaken impression that claimant had used "excellent protective practices" and that he was rarely exposed to hazardous chemical fumes at work. (Ex. 14-5, Tr. 64,[3] 71-72[4]; *see* Ex. 14-1). Dr. Burton also stated that claimant had given him substantially the same history as he related at hearing. (Tr. 61). But claimant clearly and graphically testified to *frequent unprotected* exposure to hazardous chemicals, especially their fumes, when unloading numerous customers' vehicles every day at work. Claimant's testimony in this regard (and his reporting to Drs. Dowsett and Flaming about his exposure) is uncontradicted. Consequently, we cannot say that Dr. Burton's assumption that claimant's exposure was negligible is based on a materially accurate history.

Dr. Burton's causation opinion also rests on a belief that claimant's work exposure was not "meaningful," only "irritating," based on claimant's symptoms. (Tr. 61-65). He acknowledged claimant's vocal chord edema findings, but stated that, for chemical exposure to affect the larynx, there would be significant ocular, nasal, and pulmonary symptoms as well. (Tr. 65). But claimant *did* have a watery right eye, nasal congestion, and a runny nose associated with his work exposures and preceding his laryngitis. He also had raw nasal passages and a rash and scabs under his nose. Dr. Burton suggested that the rash might be herpes and speculated that the laryngitis and vocal chord edema might

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[2] 109 Or App 109, 112 (1991) *rev den* 312 Or 676 (1992). The court stated: "We do not require that medical evidence consist of specific incantation or that it mimic statutory language. The Board could infer from [the doctor's] statement and the entire report that claimant's work activities were the major contributing cause of his irritant reaction and disability[.]"

[3] Dr. Burton testified:

"[Claimant] described to me using excellent respiratory protective practices. He may occasionally encounter a container that's open and so forth and experience a brief exposure to what has got to be a relatively low level. It causes odor. It may be annoying. I might even be unpleasant, but would be very unlikely to cause a medical condition."

[4] Dr. Burton testified:

"I think by the history that I have [this] would be the kind of potential exposure in moving containers from a person's trunk to a cart would be the same kind of exposure that a person at home is going to have moving it into their automobile, probably less, and for the most part they're in containers. . . .For example, there are no spills, there are no production activities that result in the release of chemical substances into the air. They're basically static containers that are moved from one location to another."

This view of claimant's work exposure fails to recognized that claimant handled toxic chemicals full time, 40 hours per week, and these materials *were* sometimes uncovered or spilled.

be due to snoring or forceful speaking. Dr. Burton's alternative explanations for claimant's symptoms are unsupported in the remainder of the record.[5] The persuasiveness of Dr. Burton's causation conclusion is further diminished by the fact that he failed to acknowledge that claimant *did* have a variety of symptoms other than hoarseness associated with his work exposures -- and they are the same type expected with exposure to hazardous chemicals.

Dr. Dowsett, treating physician, felt that exposure to hazardous waste materials, chemical solvents and other chemical irritants, as well as their fumes, caused claimant's "problems," including a chronic throat condition. (Exs. 15, 17). Dr. Dowsett's causation conclusion is based on, and supported by, an accurate history regarding claimant's work conditions and symptoms, as well as opportunities to observe those symptoms. (*See* Exs. 9, 10, 12, 17, 18, 19).

SAIF argues that Dr. Dowsett's opinion is insufficient to establish compensability, because it is based on nothing more than deductive reasoning.[6] We disagree, because Dr. Dowsett expressly relied on claimant's history in forming his conclusion that claimant's exposure to chemicals was "the most likely cause of his problems." (Ex. 17-1). As we have stated, Dr. Dowsett's opinion is based on an accurate history, but Dr. Burton's opinion is not. We also find that Dr. Dowsett's reasoning and conclusions are the most consistent with claimant's clinical course of exposure-related symptoms. Accordingly, based on Dr. Dowsett's persuasive opinion and claimant's credible testimony, we conclude that the claim is compensable.

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

ORDER

The ALJ's order dated June 15, 1998 is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the SAIF Corporation.

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[5] We note that claimant treated unsuccessfully with antibiotics, when Dr. Peck suspected viral infection as an explanation for claimant's initial complaints. No sleep disorder studies were conducted which might have shed light on whether claimant's snoring contributed to his vocal chord edema or laryngitis. No medical expert other than Dr. Burton suggested that claimant's vociferousness might have cause his throat condition or any of his other symptoms. Dr. Burton did not suggest that claimant's manner of speaking or snoring would explain the symptoms that preceded laryngitis, such as raw nasal passages and skin irritation. There is no indication that Dr. Burton has experience diagnosing herpes, sleep disorders, or vocal cord trauma. Under these circumstances, we are not persuaded that herpes, sleep apnea, or forceful speaking are likely causal contributors.

[6] Dr. Dowsett commented that he "could find no other reason for [claimant's] chronic laryngitis other than toxic exposure." (Ex. 17-1).

In the Matter of the Compensation of
PAMELA T. SMITH, Claimant
WCB Case Nos. 98-00006 & 98-00004
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation, on behalf of Good Samaritan Hospital (SAIF/Good Samaritan), requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its responsibility denial of claimant's "new occupational disease" claim for her current bilateral carpal tunnel syndrome (CTS) and de Quervain's disease; and (2) upheld SAIF's responsibility denial, on behalf of Wolfe Manufacturing, Inc. (SAIF/Wolfe), of the same conditions. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

In July 1988, claimant developed wrist symptoms while employed at SAIF/Wolfe. SAIF/Wolfe accepted disabling bilateral de Quervain's disease and CTS. The claim was closed on April 26, 1990, with an award of 5 percent scheduled permanent disability for each forearm.

From that time until claimant began working at Good Samaritan in 1995, she experienced intermittent discomfort that remained at the same level, and which she self-treated with over-the-counter anti-inflammatories. (Tr. 16, 17, 18, 20).

Claimant's job duties at Good Samaritan required extensive use of the hands and wrists. (Exs. 46, 63A; Tr. 10, 11). In August 1997, claimant experienced worsened symptoms, including bilateral wrist pain and swelling, nocturnal paresthesia, and pain into the thumbs. (Ex. 47). Dr. Welch diagnosed bilateral de Quervain's tenosynovitis, tendinitis, and CTS. (Exs. 49, 51). He treated both wrists with injections, which were successful in diminishing her symptoms on the left, but not the right. On October 24, 1997, Dr. Welch performed a right first dorsal compartment and carpal tunnel release. (Ex. 55). Claimant was subsequently evaluated by Dr. Mayhall for SAIF. (Ex. 59).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that SAIF/Good Samaritan is responsible for claimant's current wrist conditions under ORS 656.308(1), finding that claimant suffered a new occupational disease resulting from work activities at Good Samaritan Hospital. On review, SAIF/Good Samaritan contends that the ALJ incorrectly evaluated the medical evidence regarding the responsibility issue and that the greater weight of the evidence establishes that SAIF/Wolfe is responsible for claimant's current wrist condition. After conducting our review, we agree that responsibility for the claim rests with SAIF/Wolfe.

An employer with an accepted injury or occupational disease remains "responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1). Thus, responsibility remains with SAIF/Wolfe unless the record establishes that claimant sustained a new occupational disease. To establish a new occupational disease, the record must demonstrate that claimant's employment conditions subsequent to 1990 were the major contributing cause of the combined condition and pathological worsening of her disease. ORS 656.802(2)(b); *Jack L. Barbee*, 48 Van Natta 1855 (1996); *Tivis E. Hay*, 48 Van Natta 558, 560 (1996).

Because claimant's wrist conditions have existed for about nine years, and because there are multiple causal factors involved in claimant's conditions, determining the "major" causal factor presents a complex medical question which must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or 279, 283 (1993). For the following reasons, we conclude that the record does not support the claim against SAIF/Good Samaritan.

When Dr. Mayhall examined claimant for SAIF in November 1997, he reported that claimant had had bilateral wrist aching for many years, which had worsened in 1997 while she was working for Good Samaritan. Dr. Mayhall was unable to attribute the worsening of the preexisting condition to her work activities at Good Samaritan, because the conditions had progressed over time, even without subsequent work exposure. (Ex. 64-1). The doctor also noted that claimant has underlying preexisting risk factors such as a recent weight gain of 30 pounds, female gender, age and an elevated wrist index.[1] At the most, Dr. Mayhall opined that claimant's preexisting risk factors were the major contributing cause of her combined wrist conditions and that her work at Good Samaritan was only the precipitating cause of her current conditions. (Ex. 59). Dr. Mayhall's opinion is insufficient to establish a compensable occupational disease.

Dr. Welch, claimant's attending surgeon, initially opined that claimant's work activities at Good Samaritan caused a worsening of her underlying condition that directly resulted in her need for treatment, including surgery. (Ex. 54). After claimant's attorney requested a clarifying report, Dr. Welch opined that claimant had experienced a mild pathological worsening of her underlying preexisting wrist conditions, as revealed by the 1997 nerve conduction studies. However, he was unable to to say whether claimant's work activities at Good Samaritan were the major contributing cause of the combined condition. On the one hand, he opined that, if claimant had experienced only low level symptoms between 1991 and 1997, which worsened in 1997, then the major contributing cause of her current condition was her work at Good Samaritan. Conversely, he opined that if her earlier flares had been similar to her current flare at Good Samaritan, then the major contributing cause would be her preexisting condition. Finally, he noted that the medical records from 1991 to 1997 were not available to him, and concluded that claimant's "situation" was "one with a multi-factorial cause for her symptomatology and need for treatment."

Moreover, although claimant's attorney specifically had asked Dr. Welch about the effect of the risk factors identified by Dr. Mayhall that preexisted her current condition, Dr. Welch did not address his question. (Ex. 63B). Consequently, we discount Dr. Welch's opinion because he did not weigh the relative contributions of claimant's preexisting conditions, as required under *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 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).

There is no other medical opinion in the record relating claimant's current bilateral wrist conditions in major part to the conditions of her employment at Good Samaritan. Without persuasive medical evidence to support a new occupational disease claim against SAIF/Good Samaritan, SAIF/Wolfe, under its 1988 claim, remains responsible for claimant's current right wrist conditions under ORS 656.308. Consequently, we reverse that portion of the ALJ's decision that placed responsibility for claimant's wrist conditions on SAIF/Good Samaritan. Moreover, given this conclusion, we also reverse the ALJ's assessment of a $1,000 attorney fee for prevailing over SAIF/Good Samaritan's responsibility denial.

However, by virtue of this order, SAIF/Wolfe's responsibility denial has been overturned. For finally prevailing over SAIF/Wolfe's responsibility denial, claimant's counsel is entitled to an attorney fee for services at hearing and on review. ORS 656.308(2)(d); *Paul R. Huddleston*, 48 Van Natta 4, *on recon* 48 Van Natta 203 (1996); *Julie M. Baldie*, 47 Van Natta 2249 (1995). Claimant neither asserts nor do we find "extraordinary circumstances" warranting an attorney fee in excess of the statutory maximum $1,000 attorney fee. *See Jack L. Barbee*, 48 Van Natta 1855, 1858 (1996). Therefore, claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review, payable by SAIF/Wolfe. *See Tammy Locke*, 48 Van Natta 250 (1996) ($1,000 attorney fee limitation under ORS 656.308(2)(d) is cumulative for all levels of litigation).

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[1] "Preexisting condition" is defined, in part, 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 * * *." ORS 656.005(24).

ORDER

The ALJ's order dated April 15, 1998 is reversed in part and affirmed in part. That portion of the order that set aside SAIF/Good Samaritan's responsibility denial is reversed and the denial is reinstated and upheld. That portion of the order that upheld SAIF/Wolfe's denial is reversed, the denial is set aside, and the claim is remanded to the SAIF Corporation, on behalf of Wolfe Manufacturing, Inc., for processing according to law. In lieu of the ALJ's $1,000 attorney fee award against SAIF/Good Samaritan, claimant's attorney is awarded $1,000, to be paid by SAIF/Wolfe.

In the Matter of the Compensation of
ARTHUR SWEETING, Claimant
WCB Case No. 97-09901
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Hoffman Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) found claimant's claim for a low back strain and L4-5 disc herniation was not prematurely closed; and (2) declined to award temporary disability benefits for the period of February 7, 1996 to November 15, 1996. On review, the issues are premature closure and temporary disability. We affirm.

FINDINGS OF FACT

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

Claimant, age 50 at the time of hearing, compensably injured his low back on November 20, 1994. Claimant's attending physician, Dr. Emory, recommended surgery, and referred claimant to Dr. McGirr, a neurosurgeon, who concurred. Claimant was fearful of surgery and obtained another opinion. Dr. Golden also concurred in the recommendation for surgery. Claimant continued to resist surgery, participating in additional physical therapy, with minimal improvement.

Claimant was evaluated at Oregon Health and Rehabilitation (OHR) and diagnosed with post-traumatic stress disorder (PTSD) secondary to childhood events and compounded by his experiences in Vietnam during the war. Dr. Holmes, medical director of OHR, reported that claimant was determined to avoid surgery for his compensable injury and was very motivated toward non-surgical treatment. Dr. Holmes subsequently determined that psychological treatment, directed toward claimant's PTSD and phobias, was necessary to enable claimant to accept surgery.

During August 1995, claimant saw John Stacey, PhD, regarding his PTSD and fears of surgery. Claimant also returned to Dr. McGill on August 1, 1995, who continued to recommend surgical intervention.

In November 1995, the employer's claims processor denied claimant's PTSD as unrelated to his compensable injury. This denial later became final by operation of law.

On November 28, 1995, claimant was evaluated by Drs. Strum and Brooks at the employer's request. They opined that, absent surgical intervention, claimant's compensable injury was medically stationary.

On January 30, 1996, Dr. McGirr reported that insofar as more than a year had passed since claimant's disc herniation, surgery was probably no longer indicated. He concluded that claimant had achieved medically stationary status. On February 6, 1996, Dr. Emory opined that, in light of claimant's refusal to undergo surgery, his back condition was medically stationary. Dr. Emory also reported that claimant had a symptomatic disc but was released to work pending a physical capacity evaluation.

In May 1996, claimant wrote to the Workers' Compensation Department requesting administrative review of his need for psychological counseling. On November 15, 1996, the Director issued an Administrative Order finding that claimant's phobias and the psychological counseling would do nothing to improve his strain and/or disc herniation. The Director concluded that the psychological treatment was not appropriate or reimbursable.

In January 1997, claimant was examined by Dr. Tsai, who also performed a records review. On April 29, 1997, Dr. Tsai reported that so long as claimant declined both epidural injection and surgery, he was medically stationary by his own decision.

Claimant's claim was closed pursuant to a July 16, 1997 Notice of Closure finding that claimant's condition became medically stationary on February 6, 1996. Claimant was awarded temporary disability through February 6, 1996 and 32 percent unscheduled permanent disability for his low back. Claimant requested reconsideration. A December 3, 1997 Order on Reconsideration affirmed the Notice of Closure in all respects.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that because claimant declined surgery and did not obtain psychological counseling to address his fears and phobias and allow him to accept surgery, he was medically stationary as of February 6, 1996. The ALJ therefore concluded that claimant's claim was not prematurely closed.

On review, claimant concedes that he was medically stationary as of the July 16, 1997 Notice of Closure.[1] Claimant argues, however, that he was not medically stationary on February 6, 1996, and that, as a matter of law, he did not become medically stationary until November 15, 1996, when the Director determined his psychological treatment was not appropriate or reimbursable. Consequently, claimant seeks an award of additional temporary disability for the period of February 7, 1996 to November 15, 1996. We find that claimant is not entitled to such additional compensation, for the reasons set forth below.

Because claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. A worker's substantive entitlement to temporary disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the worker was disabled due to the compensable injury before being declared medically stationary.[2] ORS 656.210; *See Santos v. Caryall Transport*, 152 Or App 322 (1998); *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992) ("Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date.")

Here, notwithstanding claimant's contention that his entitled to additional time loss because he did not "substantively" become medically stationary until November 15, 1996, the record establishes that he was, in fact, medically stationary as of February 6, 1996.[3] On that date, his attending physician, Dr. Emory, specifically reported that claimant's back condition was medically stationary in light of his decision to decline surgery. We have previously held that, in cases in which a claimant's medically stationary status is contingent upon undergoing recommended surgery, a claim is not prematurely closed if the claimant refuses the surgery. *See, e.g., Karen T. Mariels*, 44 Van Natta 2452, 2453 (1992); *Stephen L. Gilcher*, 43 Van Natta 319, 320 (1991).

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[1] Given this concession, it is unnecessary for us to address the issue of whether the claim was prematurely closed. The disputed issue is claimant's substantive entitlement to temporary disability subsequent to February 6, 1996.

[2] "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

[3] In any event, as noted above, for purposes of determining claimant's substantive entitlement to temporary disability, the determinative factor is not the claimant's medically stationary date, but rather, whether the worker was at least partially disabled due to his compensable injury during the period in dispute. *See* ORS 656.210, 656.212. *See also Darlene L. Bartz*, 47 Van Natta 134 (1995) (a claimant is not substantively entitled to temporary disability benefits through her medically stationary date in the absence of proof that she was disabled due to her compensable condition through that date).

We recognize that, in this case, claimant's psychological condition prohibited him from agreeing to the recommended surgery. We also acknowledge that, at least initially, claimant sought psychological treatment in hopes of overcoming his fears and phobias and that he requested (and was ultimately denied) authorization for continued counseling in connection with his accepted injury. The Department's order establishes, however, that the psychological counseling was not appropriate treatment for his compensable condition. Consequently, the fact that claimant pursued such inappropriate treatment does not alter the medically stationary date of his compensable injury nor his substantive entitlement to temporary disability benefits. *See, e.g., Thomas E. Suby*, 50 Van Natta 1088 (1998) (a Director's final determination that medical treatment was not appropriate breaks the chain of causation between the accepted injury and the associated substantive temporary disability benefits).

ORDER

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

November 5, 1998 Cite as 50 Van Natta 2166 (1998)

In the Matter of the Compensation of
JASON L. WINNETT, Claimant
WCB Case No. 98-01940
SECOND ORDER OF DISMISSAL
Meyers, Radler, et al, Defense Attorneys

On September 14, 1998, we withdrew our August 14, 1998 order that dismissed claimant's request for Board review on the ground that the record did not establish that all parties received timely notice of claimant's request. *Jason L. Winnett*, 50 Van Natta 1589 (1998). We took this action to consider claimant's contention that he had timely notified the self-insured employer's "legal representative" of his appeal. Having received the parties' respective positions, we proceed with our reconsideration.

On June 5, 1998, the Administrative Law Judge (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 was its July 7, 1998 receipt of the Board's acknowledgment letter.

On August 14, 1998, we issued an order dismissing claimant's request for review on the ground that the record failed 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.

On September 14, 1998, we received a letter from claimant objecting to our August 14, 1998 Order of Dismissal and suggesting that he had mailed a copy of his request for Board review to the carrier's "legal representative." We treated claimant's letter as a motion for reconsideration of our dismissal order. On that same date, we abated our August 14, 1998 order to allow the carrier to respond to claimant's motion.

On September 25, 1998, we received the carrier's response to our abatement order. The response indicated that the carrier had not received a copy of claimant's motion for reconsideration.[1]

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[1] We included a copy of claimant's motion for reconsideration with the employer's counsel's copy of our September 28, 1998 letter.

On September 28, 1998, we wrote the parties asking for clarification regarding whether the employer, its insurance carrier or its legal counsel had received a copy of claimant's request for Board review. We also requested that claimant clarify whether he mailed a copy of his June 26, 1998 request for Board review to the employer, its carrier, or to their attorney and, if so, when.

We received the employer's response to our letter on October 13, 1998. In its response, the employer indicated that neither the employer, its processing agent, nor its attorney had received copies of claimant's request for review and that they did not have knowledge of an appeal until the Board's acknowledgment of the request for review was received.[2] Claimant's response to our September 28, 1998 letter was received on October 13, 1998. In his response, claimant stated that he mailed a copy of his appeal to the Board and to the carrier's attorney. Claimant did not specify when the copy of the appeal was mailed to the carrier's counsel.

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). In the absence of a showing of prejudice, timely service on the carrier's counsel is adequate compliance with ORS 656.295(2) and vests the Board with jurisdiction, even if copies of the appeal were not provided to the employer and its claim administrator. *See Deborah J. Layton*, 46 Van Natta 436 (1994); *Allasandra O'Reilly*, 40 Van Natta 1180 (1988).

Here, claimant has indicated that he sent a copy of his request for review to the carrier's attorney. Claimant does not indicate, however, on what date or to what address he mailed the copy. In addition, the carrier's attorney contends that he did not receive the request for review. Under such circumstances, we are not persuaded that a copy of claimant's request for review was timely mailed to the carrier's attorney.

In reaching this conclusion, we distinguish *Deborah J. Layton*, which we cited above. In *Layton*, the claimant represented that she mailed copies of her request for review to the other parties on the same day that she mailed her timely request to the Board. The self-insured employer's counsel acknowledged receiving a copy of the request for Board review in an envelope which bore a postmark dated within 30 days of the ALJ's order. We found, based on the claimant's unrebutted representation, which was confirmed by the employer's counsel, that the claimant timely mailed copies of her request for Board review to the other parties to the proceeding.

In the present case, unlike in *Layton*, claimant did not specify the date on which he mailed the copy of the request to the employer's counsel. Moreover, the employer's counsel in the present case did not actually receive a copy of the appeal. Under these circumstances, we are not persuaded that claimant timely mailed his request to the carrier's attorney.

We likewise distinguish *David J. Gordon*, 48 Van Natta 1450 (1996). In that case, the employer's counsel never received a copy of the claimant's request for review, but there was no contention that the employer or its processing agent were not served with a timely notice of the appeal. We held that the employer received timely notice of the claimant's request for Board review.

In the present case, in contrast to *Gordon*, neither the employer's counsel, the employer nor its processing agent received timely notice of the appeal.

Accordingly, as supplemented herein, we republish our August 14, 1998 order that dismissed claimant's request for Board review is dismissed.

IT IS SO ORDERED.

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[2] The Board's acknowledgment of the request was mailed on July 6, 1998 and was not received by the employer until July 7, 1998, more than 30 days from the date of the ALJ's order.

In the Matter of the Compensation of
VICKI L. DANFORTH, Claimant
WCB Case No. 97-09123
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its denial of claimant's injury claim for right wrist conditions; (2) awarded temporary disability benefits; and (3) assessed a penalty for untimely payment of interim compensation. On review, the issues are compensability, temporary disability, and penalties.

We adopt and affirm the ALJ's order, with the following supplementation to address the employer's arguments on review.

We begin with a summary of the pertinent facts. Claimant, who is right-handed, started working at the employer on June 9, 1997. She was absent due to illness for three days during her second week of employment and for one day on July 18, 1997 for the same reason.

Claimant's duties included laying carpet in trailers, which required repetitive use of her hands. On July 28, 1997, she experienced a "pop" in her right wrist, accompanied by minor pain. Her wrist popped several more times during the day, and by the end of her shift the pain was severe. Claimant was unable to operate a staple gun the next day. The employer provided her with a wrist wrap and assigned her to a different job crimping wires with her right hand. By the end of the week, claimant had developed numbness and tingling in her right hand and fingers.

On August 4, 1997, claimant sought treatment from Dr. Minogue, internist, for her wrist and hand complaints. Dr. Minogue released her to light work without use of the right arm. Claimant returned to modified work the next day. At the end of her shift on August 6, 1997, the employer terminated her employment.

In October 1997, claimant was evaluated by Dr. Radecki.

Dr. Minogue referred claimant to Dr. Warren, orthopedist, who evaluated her wrist on November 11, 1997.

Dr. Warren referred claimant to Dr. Isaacs, neurologist, for further evaluation. Dr. Isaacs examined claimant on December 23, 1997.

Compensability

The ALJ concluded that claimant proved that she sustained a compensable injury to her right wrist at work on July 28, 1997, which, combined with continued use of her right hand at work, resulted in carpal tunnel syndrome (CTS). The ALJ based his conclusion on the opinions of treating physician Dr. Minogue, consulting orthopedist Dr. Warren, and consulting neurologist, Dr. Isaacs. On review, the employer contends that the ALJ should not have relied on those opinions because they were based on a faulty history that claimant had not used various hand tools and performed construction work on a regular basis.

At the outset, we note that the employer does not dispute that the July 28, 1997 injury happened. The issue is whether medical causation is proven.

Based on her demeanor at hearing, as well as the substance of her testimony, the ALJ concluded that claimant was credible. Although we generally defer to the ALJ's demeanor-based credibility finding, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). Even minor inconsistencies can be a sufficient basis to disagree with the ALJ's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. *See, e.g., David A. Peper*, 46 Van Natta 1656 (1994).

Here, however, we do not find that the factual inconsistencies between the somewhat exaggerated experience regarding her use of tools that claimant provided on her job application, her inaccurate guesses as to the weight or distance she carried carpeting, or the other minor inconsistencies relied on by the employer (nailing a roof on one occasion and feeding chickens and a calf prior to her employment) rise to a level that we must conclude that claimant's material testimony regarding her medical history is not credible.

First, there is no medical evidence that claimant experienced any wrist symptoms prior to her work at the employer. (*See* Ex. 14-1, 14-5). Moreover, there is no evidence that claimant experienced any wrist symptoms prior to the July 28, 1997 incident at work when she was installing carpet. In addition, there is no evidence that the work provided by the employer subsequent to the injury did not involve the repetitive use of claimant's right wrist. Finally, there is no evidence that the incident claimant experienced at work occurred in any manner other than that she consistently reported to all the doctors who treated or examined her and testified to at hearing. Accordingly, based on claimant's credible testimony and the consistent medical histories, we find that claimant injured her right wrist while installing carpet at work on July 28, 1997 and that she has experienced right wrist symptoms since that time.

The employer next contends that there are no objective findings of an actual condition in the right wrist. We disagree.

Dr. Minogue, who treated claimant in August 1997, found a positive Tinel's sign, which led him to suspect CTS; he recommended nerve conduction studies (NCS). (Ex. 2). Dr. Radecki performed NCS on October 15, 1997. Dr. Radecki found the NCS normal, with the exception of the median sensory study, which was slightly greater but still within the range of normal. He attributed claimant's wrist symptoms to either functional overlay or psychosocial factors. Ex. 8).

Dr. Warren found no evidence of functional overlay, malingering, or hysteria, and reported that Dr. Minogue had not made such findings either. Dr. Warren found positive Phalen's and Tinel's tests, abnormal sensation in the median nerve distribution, and difficulty with two point discrimination in the median nerve distribution. (Exs. 11, 13).

Dr. Isaacs, who first examined claimant about four and a half months after the injury, in December 1997, reported tenderness over the extensor tendon origins, pain with range of motion, and a positive Finklestein's test. Dr. Isaacs opined that these findings indicated a focal injury to the wrist, probably involving a ligament or tendon. Moreover, although he reported that claimant showed no electrophysiologic evidence of fixed medial neuropathy at the wrist, he opined that such a finding did not exclude intermittent symptoms, and because claimant's symptoms had improved by the time of his December 1997 examination, he concluded that claimant had mild median nerve irritation, without injury to the nerve, and with features of carpal tunnel syndrome. (Exs. 14, 15).

Based on this record, we find that claimant's responses to the clinical testing by both Dr. Warren and Dr. Isaacs constitute "verifiable indications of disease" which were "reproducible." Therefore, we conclude that claimant has established compensable conditions supported by "objective findings." *See* ORS 656.005(19).

Interim Compensation

The ALJ found that claimant's temporary employment had not been terminated for violation of work rules or other disciplinary reasons and awarded claimant temporary total disability payments beginning August 7, 1997. The employer contends that, because claimant had been terminated for cause, she is not entitled to these benefits. We disagree.

As a preliminary matter, we note that this dispute does not involve claimant's entitlement to temporary partial disability benefits, whether in the form of interim compensation or temporary partial disability benefits. That is, there is no dispute that claimant has some injury-related limitations which restrict her to modified work. Rather, the issue here is whether claimant is entitled to receive temporary total disability benefits following her termination.

Temporary partial disability benefits shall be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer OAR 436-060-0030(8). This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. For the purpose of this rule, when a worker who has been doing modified work quits the job or the employer terminates the worker for violation of work rules or other disciplinary reasons it is not a withdrawal of a job offer by the employer, but shall be considered the same as the worker refusing wage earning employment pursuant to ORS 656.325(50(a). This section does not apply to those situations described in sections (5), (6) and (7) of this rule. OAR 436-060-0030(8).[1]

Claimant was injured on July 28, 1997. On August 4, 1997, Dr. Minogue released her to modified work. Claimant returned to work and performed her modified work successfully through August 6, 1997, at which time she was called into a meeting with Todd Dowler, safety environmental coordinator, and Tim Fox, her immediate supervisor. Claimant testified that her termination was carried out by Mr. Fox, who told her that she was fired "due to circumstances," but did not explain those circumstances.

At hearing, Mr. Dowler testified that claimant was absent from work during her third week on the job for three days due to illness and for one day on July 18, 1997 for the same reason. (Tr. 81). Mr. Dowler also testified that there was no other indication in the file that claimant had any other illness-related absences or other reasons for reduced hours. (Tr. 82).

The ALJ left the record open for additional evidence concerning the interim compensation issue. Mr. Dowler provided a post-hearing affidavit stating that claimant was terminated because of three unauthorized periods of absence and her failure to progress to an acceptable level of proficiency during her 60-day trial period. We agree with the ALJ's analysis and conclusion that claimant was not terminated for violation of work rules or other disciplinary reasons, as there was no evidence that the employer advised claimant prior to her injury that she was not performing her job as required or that there was an attendance deficiency. Moreover, if there were attendance problems, there was no explanation why claimant was not terminated prior to her injury. Nor does the record contain any explanation as to why claimant's absences due to illness amount to "unauthorized absences" pursuant to the employer's work rules. Therefore, claimant is entitled to temporary total disability payments beginning August 7, 1997.

Penalties

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

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 the compensability and temporary disability issues, 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 these issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved. Claimant is not entitled to an attorney fee for services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated June 23, 1998 is affirmed. Claimant's counsel is awarded a fee of $1,500 for services on review, to be paid by the self-insured employer.

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[1] Claimant was injured on July 28, 1997. Therefore, the rules provided in WCD Order No. 96-070 are applicable in this case.

In the Matter of the Compensation of
ANA GALVEZ-ALEMAN, Claimant
WCB Case No. 98-00440
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order dismissing claimant's request for hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

We take administrative notice of the following findings of fact. On August 1, 1997, an Order on Reconsideration issued that affirmed a Determination Order. On January 9, 1998, claimant filed a request for hearing.

On April 19, 1998, the ALJ convened a hearing. On May 5, 1998, the ALJ issued an order dismissing claimant's request for hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ's order states that he granted the insurer's motion to dismiss "for two reasons." First, the ALJ found that the request for hearing was not timely. The ALJ further found that, "with respect to medical services, there is no claim and there is no denial upon which to make a decision even if the Hearings Division had jurisdiction over medical services."

The ALJ's order also explains that "[n]o exhibits were formally received." Because the ALJ did not admit any documentary or testimonial evidence, it is difficult to determine whether claimant made a claim; if that claim was only for medical services; and whether we have jurisdiction over the matter. In any event, if claimant was pursuing a claim based on a contention that unpaid medical bills were related to her accepted lumbar strain condition, jurisdiction over the dispute would rest with the Director. ORS 656.245(6); *SAIF v. Shipley*, 236 Or 557 (1998). Alternatively, in light of the insurer's procedural objection, if claimant was asserting a "new medical condition" claim, the litigation of such a dispute would likewise be dismissed as premature because claimant has made no assertion that she made a clear request for a formal written acceptance of a new medical condition. *See Billie I. Rumpel*, 50 Van Natta 207 (1998).

Furthermore, we agree with the ALJ's conclusion that claimant's request for hearing was not timely filed. Although the ALJ did not admit any evidence, we may take administrative notice of the Order on Reconsideration and the request for hearing.[1] Under ORS 656.319(4), a party's objections to a reconsideration order "shall not be granted unless a request for hearing is filed within 30 days after the copies of the reconsideration order were mailed to the parties."

Here, copies of the Order on Reconsideration were mailed on August 1, 1997. Claimant did not file her request for hearing until January 9, 1998, more than 30 days after August 1, 1997. Consequently, the ALJ correctly found that a hearing could not be granted.

ORDER

The ALJ's order dated May 5, 1998 is affirmed.

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[1] *E.g., Gaspar Lopez*, 48 Van Natta 1774, 1775 (1996). In *Lopez*, we explained that we could take official, or administrative, notice of an Order on Reconsideration because it was "an act of a state agency." We further reasoned that we could take notice of a request for hearing because it was "a matter whose accuracy cannot reasonably be questioned."

In the Matter of the Compensation of
AUDREY KEELAND, Claimant
WCB Case No. 97-08886
ORDER ON RECONSIDERATION
Glen J. Lasken, Claimant Attorney
Scheminske, et al, Defense Attorneys

The insurer requests reconsideration of those portions of our October 15, 1998 order that: (1) affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's occupational disease claim for osteoarthritis of the right knee; and (2) affirmed the ALJ's $3,300 attorney fee award for claimant's counsel's services at hearing. The insurer argues that we erred in evaluating Dr. Teal's opinion and also contends that claimant's attorney fee award at hearing should be reduced. Having received claimant's response, we proceed with our reconsideration.

In moving for reconsideration, the insurer contends that Dr. Teal's reports are insufficient to establish that claimant's entire work exposure was the major contributing cause of her right knee osteoarthritis. After reviewing the insurer's arguments, as well as the record, the ALJ's order, and our Order on Review, we continue to adhere to the reasoning and conclusion in the order. In particular, we find sufficient our analysis of the record, including our legal reasoning and conclusion that, based on Dr. Teal's reports, claimant has established that her employment activities as a waitress for the employer were the major contributing cause of her right knee arthritis condition. Thus, we decline to provide further reasoning.

The insurer contends that it had requested that claimant's attorney fee award at hearing should be reduced in the event that we set aside one of the denials. The ALJ awarded an attorney fee of $3,300 for setting aside the insurer's denials of claimant's aggravation and occupational disease claims. In our previous order, we reversed that portion of the ALJ's order that had set aside the insurer's denial of claimant's aggravation claim for a right knee condition. Nevertheless, we did not reduce claimant's attorney fee award at hearing by limiting it to services devoted to the occupational disease issue. The insurer argues that "all" of claimant's attorney's services rendered before the May 11, 1998 hearing, including the April 29, 1998 deposition of Dr. Teal, were related to the aggravation claim and claimant should not receive any attorney fee for her attorney's services rendered before the hearing.

We agree with the insurer that, because we have upheld its denial of claimant's aggravation claim, the attorney fee award at hearing should be reduced. We determine the amount of claimant's counsel's attorney fee for services at hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute at hearing were claimant's aggravation and occupational disease claims for a right knee condition. As we discussed in our previous order, the insurer denied claimant's aggravation claim on October 27, 1997 on the basis that her condition had not worsened since the last award or arrangement of compensation. (Ex. 34). At hearing, in response to the insurer's motion for "summary judgment," claimant made an occupational disease claim for osteoarthritis of the right knee. (Tr. 12). The insurer amended its denial to deny the occupational disease claim and chose to litigate the merits of that claim at that time. (Tr. 12, 13).

In analyzing the occupational disease claim, we relied on the medical record in general and in particular, on Dr. Teal's reports and deposition testimony. Many of the documents that were included in the record for purposes of the aggravation claim were also used to analyze the occupational disease claim. Therefore, we do not agree with the insurer that claimant is not entitled to receive any attorney fee award for her attorney's services rendered before the May 11, 1998 hearing.

As compared to typical compensability cases, the issue here was of average complexity. The issue was whether claimant had established an occupational disease claim for osteoarthritis of the right knee. Thirty-six exhibits were received into evidence, two of which were generated or submitted by claimant's counsel. There was one deposition, which had a 20-page transcript. The hearing lasted one

hour, fifteen minutes. Claimant testified on her own behalf. Because claimant's right knee osteoarthritis has been found compensable, she is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The value of the claim may potentially include permanent disability benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might go uncompensated.

After considering these factors, we reconsider the attorney fee award at hearing for services concerning the occupational disease claim. Specifically, after consideration of the aforementioned factors, we conclude that $2,750 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding and the risk that claimant's counsel might go uncompensated. On reconsideration, we modify the ALJ's attorney fee award at hearing to award claimant's attorney a fee of $2,750 for services at hearing concerning the occupational disease claim, payable by the insurer. We make no changes to the $1,000 attorney fee we previously awarded for claimant's attorney's services on review.

Claimant's attorney is entitled to an assessed fee for services on reconsideration concerning the compensability issue. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $250, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's response), the complexity of the issue, and the value of the interest involved. This award is in addition to the attorney fee granted by our prior order. Claimant is not entitled to an attorney fee for services on reconsideration concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

Accordingly, our October 15, 1998 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our October 15, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 6, 1998 Cite as 50 Van Natta 2173 (1998)

In the Matter of the Compensation of
MELBA J. CULVER, Claimant
WCB Case No. 98-03224
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Zimmerman, Nielsen, et al, Defense Attorneys

On October 7, 1998, we issued an order that affirmed the Administrative Law Judge's (ALJ's) order dismissing claimant's hearing request. We have now received a "Request for Board Review" of "Administrative Law Judge James W. Moller's Opinion and Order, dated October 7, 1998." Inasmuch as Member Moller was one of the reviewing members who signed the "October 7, 1998" order, we treat claimant's submission as a request for reconsideration of our decision.

We withdraw our October 7, 1998 order for reconsideration. On further consideration of this matter, we continue to find, for the reasons expressed by the ALJ and as supplemented in our previous decision, that claimant failed to establish "good cause" for her failure to timely file her hearing request.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 7, 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
LEONEL RAMIREZ, Claimant
WCB Case No. 98-00795
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that 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 claimant's arguments on review.

On review, claimant contends that the ALJ's reliance on Mr. Vanecko's testimony is misplaced, particularly since claimant does not speak English without the aid of a translator.

We recognize that claimant primarily speaks Spanish and does not have a good command of English and that his supervisor, Mr. Vanecko, does not speak Spanish, which may explain the inconsistencies between claimant's alleged reports to Mr. Vanecko regarding his hurt back prior to September 26, 1997 and Mr. Vanecko's inability to recall such reports. However, claimant's testimony was translated by an interpreter at hearing, and claimant's attorney made no objection to the interpreter or to the translation at hearing, although claimant's attorney did make two corrections in the translation that became part of the record.[1]

Claimant stated that it was about a week after the alleged incident at work that he told Mr. Vanecko that he hurt his back at work. (Tr. 11, 14). Mr. Vanecko, in contrast, stated that claimant asked only whether he had insurance coverage. (Tr. 25, 26). As a result, it is unclear that claimant actually reported to Mr. Vanecko prior to September 26, 1997 that he experienced a work injury on or about September 15, 1997. (Tr. 25). Moreover, claimant identified a witness, Mr. Sanchez, who could have corroborated his testimony at hearing. This witness was not present at hearing. (Tr. 16). Mr. Vanecko, however, reported that he had interviewed Mr. Sanchez, who was not aware of any injury to claimant on that date. (Tr. 23). Claimant's attorney made no objection at hearing to the admission of this hearsay evidence.

Claimant has the burden of proof. ORS 656.266. Where it is claimant's burden to prove the compensability of his claim by a preponderance of the evidence, corroboration of the circumstances of his injury is both material and relevant to the compensability issue, particularly in light of the employers' countervailing testimony. Here, we do not find that claimant has met his burden of proof in the remainder of the record, since the persuasiveness of the medical opinion regarding claimant's low back condition turns on claimant's establishment of an injury to his back at work. *E.g., Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977).

Therefore, we conclude that there is insufficient evidence in the record to find that claimant injured his back at work on or about September 15, 1997.

ORDER

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

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[1] Claimant's attorney corrected the interpreter's translation of "hacer" from "to do" to "to make" when claimant was relating his job duties (Tr. 5, 6), and her translation of "pain" to "hurt" when claimant was relating that he told his supervisor that his back would hurt. (Tr. 5, 6, 14, 15). Claimant does not contend, and we do not find, that these corrections were material to our deliberations.

In the Matter of the Compensation of
BRUCE A. WAGGONER, Claimant
WCB Case No. 97-09040
ORDER ON REVIEW (REMANDING)
Doblie & Associates, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Biehl and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) declined to admit any submitted exhibits into the record; (2) affirmed an Order on Reconsideration that awarded 10.97 percent (21.06 degrees) scheduled permanent disability for claimant's binaural hearing loss; and (3) awarded claimant a carrier-paid attorney fee under ORS 656.382(2). The employer requests remand, contending that the ALJ erred in refusing to admit all exhibits submitted because claimant first objected to the proposed evidence during closing arguments. On review, the issues are evidence and remand. We vacate and remand.

FINDINGS OF FACT

The employer requested a hearing raising the issue of extent of disability after an October 21, 1997 Order on Reconsideration awarded claimant 10.97 percent scheduled permanent disability for hearing loss. On November 18, 1997, the Hearings Division scheduled a hearing for January 15, 1998.

On December 18, 1997, the employer submitted proposed Exhibits 1-29.

The parties apparently agreed to submit the matter to the ALJ "on the record," *i.e.*, without a hearing.[1]

During the January 23, 1998 written closing arguments, claimant moved to "strike" the exhibits offered by the employer, contending that the employer had not established that the proposed exhibits were contained in the Department's reconsideration record.

CONCLUSIONS OF LAW AND OPINION

The ALJ admitted no exhibits, finding no "evidence" that the parties had stipulated that the proposed exhibits were contained in the reconsideration record, or that such a stipulation had been attempted. Accordingly, reasoning that the employer (the party intending to rely on the reconsideration record) had not satisfied OAR 438-007-0018(5),[2] the ALJ denied all relief requested.

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[1] The hearings file indicates that a hearing was requested and scheduled for January 15, 1998. On December 18, 1997, the employer submitted an exhibit packet. On January 23, 1998, the parties submitted written closing arguments. On February 26, 1998, the ALJ's Opinion and Order issued. Based on this information (and absent contrary indications), we infer that the parties agreed to submit the matter to the ALJ "on the record."

[2] OAR 438-007-0018(7) provides:

> "At the hearing, rather than presenting the Director's reconsideration record for admission, the parties shall present their oral or written stipulation identifying the exhibits in the hearing record which were also included in the Director's reconsideration record under ORS 656.283(7). If the parties cannot reach an agreement, any disputed portions of the Director's reconsideration record may be presented for admission."

The rule contemplates that the parties will identify at hearing which submitted exhibits were included in the reconsideration record. Implicit in the rule is that, in the absence of the parties' oral or written agreement, the ALJ must seek the parties' respective positions regarding whether each of the submitted exhibits was included in the reconsideration record. As provided in the rule, any disputed exhibits may be presented. As we explain herein, the "hearing" cannot proceed until the exhibits are identified, including those in dispute.

The employer argues that the ALJ erred in addressing claimant's evidentiary objection, because it was first raised during closing arguments. We agree that the evidentiary objection was untimely.[3] Moreover, the result of the ALJ's refusal to admit the offered exhibits is that the record is inadequately developed for review.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). In this case, there is no record[4] and the parties do not agree on what is admissible. Moreover, because there is no way for us to determine whether or not the documents submitted at hearing were submitted to the Director during the reconsideration proceeding, we are unable to decide the propriety of their admission. Therefore, we find a compelling reason for remanding. *See Lillian L. Hornik*, 49 Van Natta 57, 58 (1997); *Howard W. Cockeram*, 48 Van Natta 1447 (1996) (Board remanded to ALJ to convene hearing and develop record in order to decide admissibility of certain evidence).

Accordingly, the ALJ's order dated February 26, 1998, as reconsidered on that date, is vacated. This matter is remanded to ALJ Stephen Brown for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines achieves substantial justice.[5] Following those further proceedings, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[3] We have consistently held that an issue raised for the first time during closing arguments is not timely raised. *E.g., Sonya G. Richardson*, 48 Van Natta 1844, 1846 n. 1 (1996); *see also Knupp v. State Acc. Ins. Fund Corp.*, 79 Or App 273, 276-77 (1986) (quoting *Mansfield v. Caplener Bros.*, 3 Or App 448, 452 (1970)). Moreover, the employer, "[t]he party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on the issue." OAR 438-007-0023. (The employer bears the burden of proof here, as the challenger of the Order on Reconsideration.) Accordingly, based on our long-standing practice, the above-quoted rule, and fairness considerations, we conclude that claimant's evidentiary objection was not timely and the ALJ erred in addressing it without providing the employer an opportunity to respond. *See Donald A. Hacker* 37 Van Natta 706 (1985).

[4] In *Fister v. South Hills Health Care*, 149 Or App 214 (1997), *rev den* 326 Or 389 (1998), evidence *was* admitted at hearing, the employer's "ORS 656.283(7) objection" was untimely and the Board should not have entertained it. Here, *no evidence* was admitted, so the record is insufficiently developed for review.

[5] We express no opinion about the admissibility of the proposed exhibits under ORS 656.283(7). This is a matter to be resolved by the parties and the ALJ on remand, "at the hearing," as contemplated by OAR 438-007-0018(7). *See* note 1. We note that a "hearing" may be the presentation of the case to the ALJ based on the written record. *See Cindy M. Penturf*, 50 Van Natta 1718, n.3 (1998).

November 6, 1998 Cite as 50 Van Natta 2176 (1998)

In the Matter of the Compensation of
GENE H. GOSDA, Claimant
WCB Case No. 96-03915
ORDER OF ABATEMENT
Aller & Morrison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Claimant requests reconsideration of our October 15, 1998 Order on Remand. Specifically, claimant contends that, in addition to the $4,301.25 awarded by the Court of Appeals, his counsel is entitled to an attorney fee award for services rendered at hearing or on Board review.

In order to consider this matter, we withdraw our October 15, 1998 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY M. YELLOTT, Claimant
Own Motion No. 98-0334M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbar strain injury. Claimant's aggravation rights expired on October 25, 1994. SAIF 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 as no surgery has been proposed at this time.

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. 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] If claimant's compensable condition worsens to the extent that surgery and/or inpatient hospitalization is 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
TAMARA ZALESKI, Claimant
WCB Case No. 97-09155
ORDER ON RECONSIDERATION
Cathcart & Borden, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

On September 24, 1998, we abated our August 25, 1998 Order on Review to consider the self-insured employer's request for reconsideration. In our August 25, 1998 order, we set aside the employer's denial of claimant's claim for a slip and fall injury. On reconsideration, the employer argues that claimant's injury is not compensable because it did not occur "in the course of employment." Claimant has filed a response to the employer's argument, and we are now ready to proceed with our reconsideration.

To be compensable under Oregon workers' compensation law, claimant's injury must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363 (1994). The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. *Id.* Here, our review is limited to whether the injury occurred "in the course of employment."[1]

Claimant was injured on a private walkway when she slipped on a rock. At the time of the injury, claimant was enroute to the employer's office from a parking area. The employer's office space was located in a commercial office complex and was leased by the employer from a private landlord.

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, the injury occurs "in the course of employment" only if the employer exercises some "control" over the place where the injury is sustained. *Norpac*, 318 Or at 366-369; *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[.]" *Norpac*, 318 Or at 366-369. Ownership, or even a leasehold interest in the place where the injury occurred, is not always required; it is sufficient if the employer has some kind of right of passage, as in the case of common stairs, elevators or passage ways through which the employer has something equivalent to an easement. *Henderson v. S.D. Deacon Corp.*, 127 Or App 333 (1994), *citing* 1 Larson, *Workmen's Compensation Law* 4-132, Sect. 15.43 (1990).

On reconsideration, the employer argues that claimant's injury is not compensable because there is no evidence that its control over the place of injury was "actual" rather than "constructive." In support of that argument, the employer relies on the Board's decision in *Janet V. Dollens*, 42 Van Natta 2004 (1990). The claimant in *Dollens* worked for an employer engaged in providing food services for a complex owned and maintained by an airplane manufacturing company. Under the food services contract, the employer had the right to such use of the complex as was necessary to perform the contract. The claimant sustained an injury when she fell in the complex parking lot, enroute to the employer's time clock in the complex. The ALJ found the injury compensable because the employer had "constructive" control over the parking lot. The Board concluded that the injury did not occur "in the course of employment" because the employer did not exercise "actual" control over the parking lot. In so ruling, the Board reasoned that the employer did not own property within the complex and was not responsible for performing or sharing in the cost of maintenance of the parking lot. *See also Karen Manning-Robinson*, 44 Van Natta 413, 414 (1992) (employer must exercise actual control over place of injury to satisfy the "in the course of employment" requirement).

Here, the employer contends that its use of the walkway as an appurtenance to the leased building is not sufficient to establish "actual" control because the record does not otherwise contain additional evidence to support that finding. Specifically, the employer notes that there is no evidence that it ever fixed, removed snow or ice from, or otherwise maintained the walkway in any other way. The employer also relies on the provision of the lease agreement making the landlord responsible for the maintenance and repair of sidewalks. The employer further notes that there is no evidence that the lease specifically entitled the employer to require that the landlord make repairs to the walkway.

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[1] On reconsideration, the employer does not contend that claimant's injury did not "arise out of" her employment.

We are not persuaded by the employer's argument and conclude that the record establishes the requisite "actual" control over the walkway where claimant was injured. That walkway connected the employer's office and the parking area, and the employer leased the office space "together with the appurtenances thereto," which included the walkway and spaces in the adjacent parking lot. In addition, the walkway was one of two routes the employer required claimant to use in accessing the office building, it was not generally used by the public, and it surrounded a common area with picnic tables that the employer allowed its employees to use to smoke and take breaks and lunch hours. Furthermore, while the lease agreement does not expressly state that the employer has the right to require the landlord to make repairs to the walkway, that right is implicit in the terms of the lease. Specifically, the lease expressly provides that the landlord is responsible for "maintenance and repair of sidewalks", and that "[t]ime is of the essence with respect to" the landlord's performance under the lease. Finally, the lease agreement requires the employer to pay its share of "[a]ll costs of operating and maintaining the Building and related improvements," which includes the walkway.

In summary, after reconsidering the record, we find that the employer exercised sufficient "actual" control over the place of claimant's injury to make that injury a compensable exception to the "coming and going" rule. *Accord Henderson*, 127 Or App at 333 (injury in elevator while leaving office building leased by employer "in the course of employment" where the employer was required to pay its share of normal maintenance and repairs of the building under the lease agreement, and the employer could require the landlord to maintain and repair the elevator); *Montgomery Ward v. Cutter*, 64 Or App 759 (1983) (injury in shopping mall parking lot while enroute to work in mall office leased by employer "in the course of employment" where: injury occurred in parking area through which the claimant was required by her work to travel repeatedly on a daily basis; injury occurred in portion of lot where she was required by the employer to park; the employer could have required the shopping mall to make repairs in the parking lot; and the employer paid a common area fee for regular maintenance and supervision of the parking lot). *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).

Finally, claimant's attorney is entitled to an additional assessed fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for these services is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time spent in responding to the employer's request for reconsideration (as represented by claimant's written 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 25, 1998 order. Claimant is awarded an additional $500 assessed fee for his attorney's services on reconsideration, to be paid by the self-insured employer. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT NICKLE, Claimant
Own Motion No. 97-0380M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, *pro se*, requests reconsideration of our September 22, 1998 Own Motion Order, in which we affirmed the SAIF Corporation's July 15, 1998 Notice of Closure. In his request, claimant contends that his compensable condition worsened in August 1998 requiring further surgery demonstrating that he was not medically stationary at the time his claim was closed.

On October 12, 1998, we abated our September 22, 1998 order, and allowed SAIF 14 days in which to file a response to the motion. The time for a response having expired, we proceed with our review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he 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 on subsequent developments*. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

Claimant contends that his condition worsened in August 1998 and that he eventually underwent a hip reduction on September 30, 1998. However, he does not offer any medical documentation which supports a conclusion that his compensable condition was medically stationary at the time his claim was closed on July 15, 1998. In this regard, we reiterate our previous finding that Dr. Rosenzweig's, claimant's treating physician, medical opinion supported the conclusion that claimant was medically stationary at the time of closure. Claimant does not offer any new medical evidence which would persuade us to come to a contrary conclusion.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that SAIF's closure was proper.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 22, 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] 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 since the July 15, 1998 Notice of Closure to the extent that surgery and/or inpatient hospitalization was 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
PETER D. WILMOT, Claimant
WCB Case No. 97-09084
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Michael Johnson's order that set aside its denial of claimant's left shoulder injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

In the second paragraph on page 2, we change the first sentence to read: "In late June/early July, claimant injured his left shoulder in a boating accident. (Tr. 17, 61, 63)." We delete the sixth sentence in that paragraph.

In the fifth paragraph on page 2, we replace the second and third sentences with the following: "Dr. Veldstra referred to claimant's work injury involving the trash cans and commented that this had 'happened once before about two months ago when he was out using inner tubes with a boat.' (Ex. 3-3)."

In the second full paragraph on page 3, we replace the third and remaining sentences in the paragraph with the following:

> "Dr. Nolan felt that, although the cause of claimant's August 17, 1997 injury was related to activities at work, the shoulder condition was preexisting with instability that facilitated the reinjury. (Ex. 20-3)."

In the last paragraph of the findings of fact on page 3, we delete the second sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant testified that he injured his left shoulder in a boating accident in late June/early July. (Tr. 17, 61, 63). He said it felt like the left shoulder came out of the socket. (Tr. 16). He did not obtain any medical care. (*Id.*) According to claimant, he had left shoulder discomfort for about one week after the boating accident and then recovered. (Tr. 16, 30).

On August 17, 1997, claimant injured his left shoulder when he was working in the stock room and five to six large garbage cans rolled from a top shelf. (Exs. 1, 2). The employer issued a denial of compensability. (Ex. 17).

The ALJ relied on Dr. Davis' opinion that there was no combination between the August 17, 1997 work injury and any residuals from the boating accident. The ALJ found no evidence of a "combined" condition and applied a material cause standard of proof. The ALJ concluded that the left shoulder claim was compensable.

On review, the employer argues that claimant was not a credible witness. The employer contends that claimant lied on the "801" form when he reported that he had not previously injured his left shoulder. The employer also asserts that claimant's history to Dr. Davis that his shoulder had not bothered him between the boating accident and the work incident was inaccurate.

The ALJ made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns an evaluation of the substance of a witness' testimony and other inconsistencies in the record, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). Even minor inconsistencies can be a sufficient basis to disagree with the ALJ's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that material testimony is credible. *See, e.g., David A. Peper*, 46 Van Natta 1656 (1994). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on the reporting is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977).

In the "801" form signed on August 17, 1997, claimant indicated that a stack of garbage cans fell on his arm and knocked it out of joint. (Ex. 1). He answered "no" to the question "[h]as body part been injured before?" (*Id.*) At hearing, claimant was asked why he answered "no" to that question. He responded:

> "A. Well, I didn't feel I wanted them to take the -- the focus away from what really happened that day. I had told them the first week back in the boating accident what happened, and that's about it.
>
> "Q. So you knew that you were giving them a wrong answer when you said, 'No'?
>
> "A. A little bit, yeah." (Tr. 23).

We are not persuaded by claimant's explanation of his answer on the "801" form.

Furthermore, we are not persuaded by claimant's testimony concerning his left shoulder symptoms after the boating accident. Claimant testified that he injured his left shoulder in a boating accident in late June/early July. (Tr. 17, 61, 63). According to claimant, he had left shoulder discomfort after the boating accident for about one week and then recovered. (Tr. 16, 30).

Claimant's testimony is inconsistent with the history given to Dr. Davis, as well as the testimony of two coworkers. In his initial exam, Dr. Davis reported that claimant said it took "about two months to get over the first [boating] episode[.]" (Ex. 9). Claimant disagreed "totally" with that portion of Dr. Davis' report. (Tr. 31).

Mr. Goodrich, a coworker, testified that he had worked with claimant rearranging the department in July 1997 and he recalled that claimant had complained on a couple of occasions that he had pain in his shoulder. (Tr. 49). Mr. Goodrich believed the conversation took place in the latter part of July. (Tr. 50, 51).

Mr. Spivey, another coworker, testified that one week before the August 17, 1997 work incident, claimant had complained about left shoulder pain while they were taking truck boxes off the risers. (Tr. 54-56). Mr. Spivey said that claimant rubbed his left shoulder and said that it was hurting. (Tr. 56). Mr. Spivey mentioned that he should file a claim if it was work-related, but he said claimant "just shrugged it off." (*Id.*)

In rebuttal, claimant testified that it was possible that he talked to Mr. Goodrich about his shoulder, but the conversation probably took place on July 9 or 10, 1997, shortly after the boating incident. (Tr. 61). Regarding Mr. Spivey's comments, claimant said that he had helped him get boxes off the risers several times and he had "no idea which time he's talking about." (Tr. 61). Claimant said he might have complained about his shoulder, but it would have been within a week of the boating accident or after the August 17, 1997 work injury. (Tr. 62).

In light of the inconsistencies in the record concerning claimant's left shoulder symptoms after the boating incident and before the August 17, 1997 injury, we are not persuaded by claimant's testimony that he recovered from the boating accident after about one week. Instead, we find more reliable Dr. Davis' initial report and the testimony of claimant's coworkers that claimant had ongoing left shoulder symptoms after the boating accident and at least up to one week before the work incident. Moreover, claimant acknowledged that he gave an incorrect answer on the "801" form. In sum, we do not find claimant to be a credible witness.

The employer contends that the opinion of Dr. Davis, which the ALJ relied upon, had an inaccurate history of claimant's left shoulder symptoms after the boating accident. The employer argues that claimant had a preexisting left shoulder condition and the major contributing cause standard applies under ORS 656.005(7)(a)(B).

We agree with the employer that the medical evidence establishes that claimant had a preexisting left shoulder condition. (Exs. 9, 18, 20-3). Furthermore, the medical evidence establishes that claimant's preexisting left shoulder condition combined with the August 17, 1997 work injury. (Ex. 20-3). Therefore, ORS 656.005(7)(a)(B) applies to this case. To establish compensability, claimant must prove that the August 17, 1997 injury was the major contributing cause of the disability or need for

treatment of his current combined condition. Given claimant's preexisting left shoulder condition, the cause of his current left shoulder condition presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420, 427 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

The record indicates that Dr. Davis changed his opinion on causation depending on his understanding of claimant's left shoulder symptoms after the boating accident. In his initial exam, Dr. Davis reported that it took "about two months to get over the first [boating] episode[.]" (Ex. 9). He indicated claimant had "bursitis to go along with chronic subluxation which was exacerbated by his recent injury." (*Id.*) In a later report, however, Dr. Davis reported that claimant had recovered without any symptoms after the first shoulder injury and, therefore, claimant's current need for care was related to the August 17, 1997 injury. (Ex. 19).

In a letter from the employer's attorney signed by Dr. Davis on February 4, 1998, Dr. Davis agreed with the following:

> "Assuming that what happened to Claimant's shoulder [during the boating accident], as described by Dr. Veldstra, was replayed on August 17, 1997, at [the employer's] store (*i.e.*, that the same sort of popping, dislocation, reduction, etc., occurred both at the inner tube incident and at the [employer's] store), and assuming that Claimant had a *history of continuing problems between the inner tube incident and the [employment] incident*, and finally assuming that it was the mechanism of reaching up to block the fall of the Rubbermaid garbage cans that caused Claimant's shoulder to sublux or dislocate, then you would agree that the most probable cause of Claimant's ongoing need for treatment after August 17, 1997, was the sequela of the non-industrial inner tube incident and not the [employer] exposure of August 17, 1997." (Ex. 21-2; emphasis added).

In a later deposition, Dr. Davis indicated that his opinion was based on a history that claimant "says he didn't have a problem and he was back at work and wasn't complaining about it and seeing anybody about it." (Ex. 22-17, -18). Based on that history, he concluded that the August 1997 work incident was the major contributing cause of claimant's current shoulder condition. (Ex. 22-6).

It is clear that Dr. Davis' causation opinion depended on his understanding of claimant's left shoulder symptoms after the boating incident. In fact, Dr. Davis testified that claimant's interim history was critical. (Ex. 22-15). As we discussed earlier, we find that claimant had ongoing left shoulder symptoms after the boating accident and at least up to one week before the work incident. Based on a history of continuing left shoulder problems after the boating incident, Dr. Davis agreed that the most probable cause of claimant's ongoing need for treatment after August 17, 1997, was the sequela of the non-industrial inner tube incident and not the August 17, 1997 work incident. (Ex. 21-2). Dr. Davis' opinion does not establish compensability.

Although claimant relies on Dr. Freudenberg's opinion on causation, we find that he did not have an accurate history of claimant's symptoms after the boating accident. Dr. Freudenberg reported that claimant had a "preexisting injury to the shoulder but he recovered from that completely." (Ex. 18). Because Dr. Freudenberg's opinion is based on an inaccurate history that claimant had completely recovered from the first injury, it is not persuasive. *See Miller v. Granite Construction*, 28 Or App at 476.

Dr. Nolan concluded that "a[l]though the cause of [claimant's] injury on 8-17-97 was related to activities at work - the shoulder condition was preexisting with instability that facilitated the reinjury." (Ex. 20-3). Dr. Nolan's opinion that claimant's August 1997 injury was "related" to his work activities is not sufficient to establish compensability under a major contributing cause standard.

After reviewing the record, we conclude that none of the medical opinions establish that claimant's August 17, 1997 work injury was the major contributing cause of the disability or need for treatment of his current left shoulder condition. Consequently, we conclude that claimant did not sustain his burden of proving compensability.

ORDER

The ALJ's order dated June 6, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
TOBIN E. WEYMILLER, Claimant
WCB Case No. 98-00953
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Marshall's order that dismissed his request for hearing for failure to appear at hearing. On review, the issue is the propriety of the order of dismissal. We affirm.

FINDINGS OF FACT

Claimant filed a claim alleging he was injured in the course and scope of his employment on June 28, 1997. Shortly thereafter, claimant moved to Japan. The insurer denied the claim by letter dated September 10, 1997.

On January 23, 1998, claimant's mother filed a request for hearing on claimant's behalf. The hearing was set for April 23, 1998. By letter dated April 17, 1998, claimant's mother requested postponement of the hearing on claimant's behalf. Following a telephone conference involving claimant's mother and counsel for the insurer, ALJ Bethlahmy denied the postponement request.

Claimant did not appear at the hearing. The insurer moved to dismiss claimant's request for hearing. On April 27, 1998, ALJ Marshall issued an Order to Show Cause, providing claimant the opportunity to explain why his case should not be dismissed. Claimant did not submit a response within the allotted time period. Thereafter, on May 12, 1998, the ALJ dismissed the case with prejudice.

Claimant requested reconsideration of the dismissal order, seeking a continuance of the hearing. On May 26, 1997, the ALJ issued an Order on Reconsideration, finding that claimant had not established sufficient circumstances to justify reinstatement of his request for hearing.

CONCLUSIONS OF LAW AND OPINION

Citing ORS 9.320,[1] the ALJ determined that, under Oregon law, claimant was required to appear at hearing, either personally or through an attorney licensed in Oregon. In light of this statutory requirement, claimant's mother (who is not an attorney licensed in Oregon) could not represent his interests at hearing. The ALJ further found that, although claimant was reluctant to travel from Japan, he had an obligation to appear at the scheduled hearing (either in person or through counsel) if he wished to pursue his claim.[2]

On review, claimant contends that the ALJ erred in not postponing the hearing until his next visit to Oregon, at some indefinite point in the future. In addition, claimant maintains that, because he is unable to meet with an attorney in person, he is apprehensive about retaining counsel and wishes to continue pursuing his claim on a *pro se* basis. For the reasons set forth below, we affirm the ALJ's dismissal order.

Pursuant to OAR 438-006-0071(2), an ALJ shall dismiss a request for hearing as abandoned if claimant or his attorney fail to appear at hearing unless "extraordinary circumstances" justify

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[1] This section provides, in pertinent part, as follows:

"Any action, suit, or proceeding may be prosecuted or defended by a party in person, or by attorney, except that the state or a corporation appears by attorney in all cases, unless otherwise specifically provided by law."

[2] Because the ALJ considered claimant's "post-dismissal order" correspondence requesting that the hearing be rescheduled, there is no need to remand this matter to the ALJ. *Compare Fred T. Hardy*, 50 Van Natta 1076 (1998) (remand appropriate where ALJ did not have the opportunity to consider motion for postponement submitted in response to a dismissal order); *Mark Totaro*, 49 Van Natta 69 (1997) (remand appropriate to consider "Motion to Postpone" when the claimant contended that ALJ's order was "erroneous" and that "injustice would result" if the ALJ's order was not reversed).

postponement or continuance of the hearing.[3] Here, claimant concedes that, prior to the date set for hearing, he was aware that his parents could not represent him at hearing.[4] He also knew that, to avoid dismissal, he had to appear at the scheduled date and time either in person or through an attorney. He did not appear, nor did he make an effort to retain counsel to appear on his behalf. In finding that claimant had abandoned his claim, the ALJ acknowledged claimant's reluctance to travel from Japan to attend the scheduled hearing, but nevertheless concluded that this circumstance did not justify reinstatement of claimant's request for hearing.

Although claimant has asserted that he is not comfortable hiring an attorney long distance and requested that the hearing be postponed indefinitely, we do not consider his reluctance to retain counsel a sufficient reason to set aside the ALJ's dismissal order. As the party who requested the hearing, claimant was obligated to appear in person or hire an attorney to represent his interest. He elected not to do either, and has not established extraordinary circumstances to justify his inaction. Accordingly, we find that the ALJ appropriately dismissed claimant's hearing request under ORS OAR 438-006-0071.

ORDER

The ALJ's order dated May 12, 1998, as reconsidered on May 26, 1998, is affirmed.

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[3] OAR 438-006-0071(2) provides:

(2) "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

[4] In his June 25, 1998 letter to the Board, claimant acknowledged that the insurer "made it perfectly clear, through a conference call back in February" that his mother could not appear on his behalf.

November 10, 1998 Cite as 50 Van Natta 2185 (1998)

In the Matter of the Compensation of
RONALD L. NISWENDER, Claimant
WCB Case No. 98-02332
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes 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 a broken collar bone. On review, the issue is whether claimant's injury arose in the course and scope of employment.

We adopt and affirm the ALJ's order. *See Kevin G. Robare*, 47 Van Natta 318 (1995) (the claimant, who commuted to work at job sites away from his employer's office, not considered a "traveling employee").

ORDER

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

In the Matter of the Compensation of
PATTY A. STAFFORD, Claimant
Own Motion No. 98-0341M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable bilateral flexor tendonitis. Claimant's aggravation rights expired on December 11, 1997. SAIF opposes authorization of temporary disability compensation, contending that: (1) it is unknown whether claimant's current condition requires surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) SAIF is not responsible for claimant's current condition; and (4) it is unknown whether surgery or hospitalization is 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.*

In its cover letter, SAIF contends that claimant's current condition (herniated disc at C4-5) and need for treatment is compensably related to a May 21, 1998 injury. (Claim No. 7857571J) SAIF further asserts that it has accepted responsibility for and is processing claimant's current condition under that claim number. We interpret SAIF's contentions to mean that claimant's current condition is not compensably related to the 1990 injury, but rather it is a newer injury for which SAIF has accepted the compensability of and responsibility for under a different claim number.

In light of these circumstances, we are without authority to authorize temporary disability compensation for claimant's current condition, as SAIF has accepted responsibility for that condition under her 1998 injury claim. Should circumstances change, and SAIF accept responsibility for her current condition under her 1990 claim, claimant may again request own motion relief.

Accordingly, the request for own motion relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY A. ENGEL, Claimant
WCB Case No. 97-08655
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's right thumb injury/occupational disease claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, supplementation, and summary. We do not adopt the last sentence of the findings of fact.

Claimant is a production worker who works in computer printer subassembly. She works with small, very light weight parts. Her job involves fine manipulation and the use of small tools, including variously angled pairs of tweezers and a hanging power driven screwdriver on a retractable line. Use of the power screwdriver requires very little pinch or grip pressure and no squeezing or twisting. The production standard was one unit every two minutes; claimant assembled one unit every 1 1/2 minutes. The production line as a whole was not reaching its goal and there were "suggestions" to work harder. At the time the claim was filed, claimant had been doing this job for seven months, and had been working for the employer about a year.

Claimant's hands were sometimes tired or sore after a busy day at work, but she had never had specific pain in an isolated area of her hand. When she started working on September 19, 1997, and throughout the morning, her hands were fine. When she returned to work after lunch, she had significant pain in the carpal-metacarpal (CMC) joint of her right hand. The pain was associated with grasping the power screwdriver.

On September 19, 1997 and September 23, 1997, claimant treated with Dr. Pierson, M.D., at an occupational health clinic. (Exs. 3, 6). Dr. Pierson diagnosed inflammation of the first CMC joint on the right hand and stated that he did not see how this was related to claimant's work. (Exs. 3, 6). He was concerned about other sources of inflammation in the joint, thought claimant might need further evaluation, and instructed her to follow-up with her primary care physician. (Exs. 6).

On December 22, 1997 and January 19, 1998, claimant treated with Dr. Madey, M.D., who diagnosed mild degenerative joint disease (DJD) of the right CMC joint based on the presence of small osteophytes in the CMC joint as shown in x-rays. (Exs. 8A, 12). This condition existed before September 19, 1997. Dr. Madey opined that claimant's pain symptoms were related to this arthritis. (Ex. 12). He also opined that, although claimant's job did not cause the arthritis, it contributed greater than 50 percent to claimant's current symptoms. (*Id.*). Prior to rendering that opinion, Dr. Madey viewed a videotape demonstrating the type of work claimant performed. (*Id.*).

On January 6, 1998, Dr. Pierson was deposed. (Ex. 9). At the time of his deposition, Dr. Pierson was not aware of the x-rays showing small osteophytes in the CMC joint or Dr. Madey's diagnosis of arthritis based on those x-rays. Prior to his deposition, Dr. Pierson viewed the videotape demonstrating the type of work claimant did and examined a power screwdriver of the type claimant used at work. In the past, Dr. Pierson had visited the employer's plant and witnessed the type of work performed there.

In his deposition, Dr. Pierson explained that he suspected that claimant has osteoarthritis in her CMC joint and, if she does, the major contributing cause of her symptoms is the osteoarthritis. (Ex. 9-16, -33-38). He explained that claimant's work activity would not injure the CMC joint and he saw no evidence of any injury; instead, he found that claimant simply had pain in her CMC joint. (*Id.* at 22, 24, 25, 26-27, 29-30, 31). He opined that claimant's work activities would not cause fatigue and pain in the CMC joint unless there was something else going on in that joint, although at that point he had no evidence of a preexisting condition. (*Id.* at 32-33, 36-37). From his examination findings, he did not think claimant's work activities were the cause of her pain. (*Id.* at 34).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the claim is correctly characterized as an injury claim. Specifically, the ALJ found that claimant's work activities on September 19, 1997, combined with her preexisting degenerative right thumb condition. Therefore, the ALJ found that, pursuant to ORS 656.005(7)(a)(B), claimant must prove that the otherwise compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. Claimant agrees that ORS 656.005(7)(a)(B) applies to her claim and asserts that she has met her burden of proof under that statute. The insurer argues that claimant's claim should be characterized as an occupational disease claim.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's current right thumb 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); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982). Nevertheless, under the circumstances of this case, we need not determine whether claimant's claim should be analyzed as an injury claim or an occupational disease claim because we find that the claim fails under either theory.

Claimant has the burden of proving that an injury or occupational disease is compensable. ORS 656.266. To establish a compensable occupational disease, claimant must prove that her employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If an occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), claimant must prove that her employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b); *Robert T. Ries*, 48 Van Natta 86 (1996).

There is no dispute that claimant has a preexisting condition, *i.e.*, arthritis or DJD in the right CMC joint, and that this arthritis condition combined with claimant's work activities on September 19, 1997. Furthermore, given the combination of the preexisting degenerative thumb condition and the work activities, 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).

The medical evidence is provided by claimant's treating physicians, Drs. Pierson and Madey, both of whom opine that claimant's work activities did not cause her arthritis condition. In addition, there is no medical evidence that the work activities pathologically worsened the preexisting arthritis condition. Therefore, the record fails to establish a compensable occupational disease claim.

As for an injury claim, ORS 656.005(7)(a)(B) provides that where a compensable injury combines with a preexisting condition, claimant must establish that the 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." *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 Liberty Northwest Insurance Corporation 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 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.

We note that, at the time of his deposition, Dr. Pierson was not aware of the x-rays that revealed claimant's osteophytes or Dr. Madey's diagnosis of arthritis based on those x-rays. However, based on his clinical examination, Dr. Pierson suspected that claimant had osteoarthritis in the right CMC joint. Furthermore, although Dr. Pierson agreed that claimant's work activities in combination with arthritis could cause increased symptoms, he opined that, assuming claimant had arthritis, the major contributing cause of the symptoms would be the arthritis.

Thus, Dr. Pierson's opinion does not support an injury claim. Moreover, even if we find Dr. Pierson's opinion unpersuasive because it was based on an assumption that claimant has arthritis in the right CMC joint, albeit an assumption that proved correct, we do not find that the remaining medical evidence meets claimant's burden of proof.

Dr. Madey rendered the only other medical opinion and stated that claimant's current symptoms of pain are related to her arthritis. He also stated that, although he did not think that claimant's job on the assembly line caused the arthritis, he thought that it "contributed greater than 50% to her current symptoms." (Ex. 12). Dr. Madey, however, did not explain why he believes that claimant's work activities contribute more to claimant's current condition than the preexisting arthritis. *See Dietz*, 130 Or App at 401-02. In fact, there is no indication that Dr. Madey weighed the relative contribution of the work activities as compared to the arthritis. *See Id.* at 401-402; *Roger A. Longbotham*, 48 Van Natta 1257 (1996) (physician's conclusions insufficiently supported because he failed to compare the contributions of off-work and work-related causes). Under these circumstances, we find Dr. Madey's opinion unpersuasive and we decline to rely on it. *See Somers v. SAIF*, 77 Or App 259 (1986); *Weiland v. SAIF*, 64 Or App 810(1983).

Accordingly, we find that claimant has failed to establish a compensable claim under either the occupational disease standard or the injury standard.

ORDER

The ALJ's order dated July 7, 1998 is reversed. The insurer's October 15, 1997 denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

In the Matter of the Compensation of
JACKIE T. GANER, Claimant
WCB Case No. 97-09610
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's consequential condition claim for a mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we briefly summarize and supplement as follows.[1]

Since 1990, claimant, a registered nurse, worked as a Staff Nurse at the employer. In May 1995, claimant underwent a total hysterectomy that resulted in complications and a nine-week absence from work.

On August 7, 1995, claimant injured her low back while transferring a patient. She experienced low back and bilateral leg pain, left greater than right. She was released to light duty work and put on a program of physical therapy. (Exs. 2, 3).

On August 26, 1995, claimant's brother-in-law, who had been a "father-figure" to her, died. (Ex. 3).

On September 29, 1995, claimant sought treatment from Dr. Rich, licensed psychologist. (Ex. 3). Dr. Rich reported that claimant presented with symptoms of depression. (Exs. 3, 27, 31).

In October 1995, claimant entered a work hardening program, with the goal of returning to her regular work. (Ex. 5). During the program, she reinjured her low back. (Exs. 4, 29-3).

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[1] We do not adopt the ALJ's notice facts.

On November 8, 1995, the employer accepted a disabling low back strain that was subsequently amended to include an L4-5 disc protrusion. (Exs. 7, 24).

Dr. Rich saw claimant again on December 6 and December 13, 1995. (Exs. 8, 9).

In April 1996, claimant sought treatment from Dr. Rodriguez, osteopath, for chest pain complaints. Dr. Rodriguez diagnosed mild depression with anxious mood, prescribed antidepressants, and referred claimant to Dr. Oseran for evaluation of her chest pain. (Exs. 10, 11).

On July 25, 1996, a notice of the end of vocational eligibility was issued because claimant refused a suitable job the employer offered her to accommodate her disability. (Ex. 14).

On September 11 and again on September 25, 1996, claimant returned to Dr. Rich. (Exs. 15, 17).

On May 12, 1997, employer-arranged medical examiners, Drs. Gambee and Gardner, examined claimant in regard to her low back injury. They diagnosed, among other things, acute depression by history. (Ex. 21).

On October 21, 1997, claimant requested that the employer amend the acceptance to include "depression." (Ex. 28).

On November 11, 1997, Dr. Turco examined claimant for the employer. Dr. Turco diagnosed reactive depression (a dysthemic disorder). (Ex. 29).

On November 19, 1997, the employer denied claimant's claim for depression, on the basis that her physical injury was not the major contributing cause of that condition. (Ex. 30).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established that her compensable low back injury was the major contributing cause of her consequential depression condition. On review, the employer contends that the ALJ erred in not applying ORS 656.802 to establish whether claimant's mental disorder was compensable, and that, in any case, the medical evidence relied upon by the ALJ is unpersuasive. We agree.

Because claimant is seeking compensation for a mental condition, the claim must be analyzed under ORS 656.802. *See* 656.802(3) (which provides that "[n]otwithstanding any other provision of this chapter, a mental disorder is not compensable" unless subparagraphs (a) through (d) are established); *Fuls v. SAIF*, 321 Or 151 (1995) (interpreting the same statutory language); *Susan B. Ables*, 50 Van Natta 833 (1998).[2] Moreover, occupational diseases are subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). ORS 656.802(2)(c). We, thus, begin by determining whether employment conditions were the major contributing cause of the disease. *See* ORS 656.802(2)(a) and 656.005(7)(a).

Claimant compensably injured her low back on August 7, 1995. She was first diagnosed with depression by Dr. Rich on September 29, 1995. (Ex. 3). The medical evidence, however, shows that multiple factors contributed to claimant's depression: interpersonal relationship issues, health issues unrelated to the compensable injury, and her concerns regarding her desire to return to her very heavy job as a Staff Nurse, despite her compensable injury. (Exs. 3, 8, 9, 15, 17, 29, 31, 34). Because of the multiple possible causes of claimant's depression, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

Opinions in support of compensability were offered by Dr. Rich, psychologist, Dr. Rodriguez, claimant's treating osteopath, and Dr. Wicher, psychologist. For the following reasons, we find none of these opinions persuasive.

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[2] Claimant contends that ORS 656.802(2) and (3) and *Fuls v. SAIF* do not apply to this case, citing our decision in *David W. Dent*, 50 Van Natta 333 (1998). The reasoning expressed in *Dent*, however, was implicitly disavowed in *Susan M. Ables*, and, in any event, is inconsistent with the Supreme Court's rationale in *Fuls*. Consequently, the *Dent* holding has not been applied.

On September 29, 1995, Dr. Rich reported that claimant was "depressed" and was crying at times. Dr. Rich's chart note contains information related to claimant's May surgery as well as her August work injury. The same chart note indicates that claimant reported a history of depression, and that she was troubled by her brother-in law's recent death, as he "had been like a father-figure" to her. Dr. Rich's September 17, 1997 letter regarding claimant's depression, however, reports only claimant's distress over changes in her work and her feelings of inadequacy as a result of changes in her job assignment. (Ex. 27). Subsequently, in her letter dated February 20, 1998, Dr. Rich noted that, in September 1996, claimant had been terminated from her employment and was experiencing both physical problems and marital difficulties. Dr. Rich elaborated on the September 1996 sessions, reporting that claimant was focused on work-related concerns, physical problems and interpersonal relationship issues. (Ex. 31).

In April 1996, claimant sought treatment for chest pain and heart palpitations. Dr. Rodriguez diagnosed claimant with mild depression, for which he prescribed medication, and possible angina. An EKG and stress test proved normal. (Ex. 10). On May 8, 1996, Dr. Rodriguez reported that claimant was doing extremely well under the medication regimen. (Ex. 13).

On September 18, 1996, claimant sought treatment for "chronic low back pain." In his chart note, Dr. Rodriguez attributed claimant's depression to her chronic back pain. (Ex. 16). In his February 20, 1998 report, Dr. Rodriguez stated that claimant's work injury was the major contributing cause of her depression. (Ex. 32). He based his conclusions on studies of other people showing a correlation between chronic pain and depression, even when the cause is undetermined. (Ex. 32-3). Dr. Rodriguez's explanation was based solely upon statistics and he failed to analyze claimant's individual circumstances. Medical analysis grounded solely in statistical analysis is generally not persuasive because it is not sufficiently directed to a claimant's individual circumstances. *See, e.g., Sueyen A. Yang,* 48 Van Natta 1626 (1996).

Moreover, Dr. Rodriguez's chart notes do not support a relationship between chronic pain generated by claimant's work injury and her depression. Although Dr. Rodriguez diagnosed depression when he initially treated claimant in April 1996 for her chest pain complaints, he did not note chronic back pain until September 1996, more than a year after claimant's work injury.

Additionally, Dr. Rodriguez's opinion does not address other contributing factors which claimant had discussed with Dr. Rich shortly after the work injury, including the pain and disability related to her May 1995 surgery, her family circumstances, and the death of a close relative. (Exs. 3, 9). Finally, Dr. Rodriguez does not explain his disagreements with the conclusions and factual information in Dr. Turco's report, and his ultimate conclusions are unexplained as well. (Ex. 36).

We agree with the employer that the opinions of Dr. Rich and Dr. Rodriguez do not establish compensability. Dr. Rich's diagnosis of depression does not relate it specifically to claimant's back injury and lacks any explanation as to how the compensable injury led to the depression condition. Dr. Rich did not explain whether or not claimant's work injury was the major contributing cause of her depression. Moreover, she did not evaluate the relative contribution of other possible causes of claimant's psychological condition. *See Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). The fact that a work injury precipitated a claimant's symptoms or condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.* Because Dr. Rich did not evaluate the relative contribution of other possible causes of claimant's psychological condition, we conclude that her reports regarding claimant's depression are not sufficient to establish compensability. Similarly, as noted above, Dr. Rodriguez also did not evaluate the relative contribution of other possible causes of claimant's psychological condition. Therefore, we conclude that his opinions regarding claimant's depression are also unpersuasive.

Finally, Dr. Wicher's opinion is unexplained and conclusory. (Ex. 5-1). Although claimant testified that she discussed the effect of chronic pain with Dr. Wicher, nothing in the medical record substantiates such a discussion or indicates whether Dr. Wicher was aware of claimant's other problems for which claimant sought psychological counseling. On this record, Dr. Wicher's opinion carries little weight. *Somers v. SAIF,* 77 Or App 259 (1986).

In the absence of medical opinion to establish that claimant's working conditions were the major contributing cause of claimant's depression, we conclude that claimant's depression is not compensable.

ORDER

The ALJ's order dated June 22, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

November 12, 1998 Cite as 50 Van Natta 2192 (1998)

In the Matter of the Compensation of
RICHARD R. HOWARD, Claimant
WCB Case No. 97-09741
ORDER ON REVIEW
Lavis & Dibartolomeo, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the insurer's denials of a low back condition claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order except for the following statement: "I interpret Dr. Etebar's opinion to be that he agrees with Dr. Farris and Dr. Bald that the preexisting degenerative disc disease was the major contributing cause of the claimant's disc herniation at L4-5 and need for treatment and surgery." We also provide the following supplementation.

We agree with the ALJ that the opinion of claimant's treating surgeon, Dr. Etebar, is insufficient to carry claimant's burden of proof under ORS 656.005(7)(a)(B). According to Dr. Etebar, claimant's "disc herniation is the major contributing cause of his current disability." (Ex. 14-1). With regard to whether the preexisting degenerative condition was the major contributing cause of the disc herniation, Dr. Etebar responded that claimant's "degenerative disc disease led to the preexisting weakness in the disc annulus leading to acute disc herniation with bending and turning at the same time." (*Id.* at 2).

Although Dr. Etebar's statement shows that the disc herniation occurred at the same time as the injurious event (bending and turning), it does not show that the injurious event was the major contributing cause of claimant's need for treatment and disability. In the absence of any other evidence making such a showing, claimant did not prove compensability.

ORDER

The ALJ's order dated July 27, 1998 is affirmed.

In the Matter of the Compensation of
RANDOLPH KING, Claimant
WCB Case No. 98-03799
ORDER OF DISMISSAL
Steven M. Schoenfeld, Claimant Attorney
Reinisch, et al, Defense Attorneys

On October 29, 1998, the Board received claimant's request for review of Administrative Law Judge (ALJ) Herman's September 8, 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 September 8, 1998, the ALJ issued an Opinion and Order upholding the self-insured employer's denial of claimant's neck and back injury claim. Copies of that order were mailed to claimant, claimant's attorney, the employer's claims processor, the employer, 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 October 29, 1998, the Board received an October 28, 1998 letter from claimant's attorney asking the Board to "begin processing this for review immediately." Attached to the correspondence was a letter dated September 16, 1998 from claimant's attorney to the Board requesting review of the ALJ's order, as well as an October 2, 1998 letter from the employer's counsel essentially acknowledging receipt of claimant's request for review.

On November 2, 1998, the Board mailed its computer-generated letter to all parties acknowledging its receipt 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. 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 September 8, 1998 order was October 8, 1998. Claimant's September 16, 1998 letter indicates that he was requesting Board review of the ALJ's order. Although the September 16, 1998 letter is *dated* within 30 days of the ALJ's September 8, 1998 order, the record fails to show that the Board *received* the request prior to expiration of the statutory 30-day period.[1] Instead, the Board's first receipt of that letter occurred on October 29, 1998, when it received the September 16, 1998 letter along with claimant's October 28, 1998 letter. Consequently, the record does not establish that claimant filed a request for review prior to the expiration of the statutory appeal period.[2]

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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. 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.

[2] Based on the insurer's counsel's October 2, 1998 letter, we are persuaded that the insurer received timely notice of claimant's request for Board review.

Considering claimant's October 28, 1998, correspondence as a request for review, claimant's filing is untimely. Therefore, 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.

November 12, 1998 Cite as 50 Van Natta 2194 (1998)

In the Matter of the Compensation of
PAUL T. MARLOW, Claimant
WCB Case Nos. 97-08080 & 97-08079
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Lane Powell Spears Lubersky, Defense Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's compensability denial of his right shoulder condition. On review, the issues are compensability, and (potentially) responsibility.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the first sentence on page 2, we change the date to "August 31, 1996."

Claimant contends that the ALJ erred in determining that he had a preexisting shoulder condition at the time of the August 31, 1996 injury. He argues that there was no "combined" condition and he asserts that the material contributing cause standard is applicable.

Even if we assume, without deciding, that claimant did not have a "combined" condition at the time of the August 31, 1996 injury, we are not persuaded that he has established compensability of his right shoulder condition.

Dr. Matheson treated claimant in the emergency room on August 31, 1996, and in followup treatment. On August 31, 1996, Dr. Matheson indicated that claimant had contusions around the face and neck, an abrasion on the left side of his face and a laceration behind the left ear. (Ex. 2-2). He did not refer to any shoulder pain or a shoulder injury. Similarly, Dr. Matheson's chart notes on September 3, 9 and 23, 1996 did not refer to any shoulder complaints. (Ex. 4). On September 23, 1996, Dr. Matheson reported that claimant's injury had resolved and the claim was closed without any impairment. (Ex. 4-2). He commented that claimant and his mother were both "quite satisfied" with the results and claimant was released without restrictions. (*Id.*)

In a later concurrence letter from the insurer's attorney, Dr. Matheson agreed that claimant had not complained of right shoulder problems or injuries on August 31, 1996 or during any of the follow-up visits in September 1996. (Ex. 31A-1). Dr. Matheson agreed that if claimant had suffered injury to his right shoulder in the motorcycle accident, he would have expected him to complain of right shoulder discomfort on August 31, 1996 or during the three subsequent visits in September 1996. (*Id.*) Dr. Matheson also agreed that it was not consistent that claimant would have suffered an acute shoulder injury and not reported any discomfort on either the day of the incident or in the thirty days thereafter. (*Id.*) He concluded that, based on claimant's shoulder complaints before the August 31, 1996 motorcycle accident and the lack of right shoulder symptoms after that incident, he could not attribute claimant's subsequent right shoulder complaints to the August 1996 accident. (Ex. 31A-2).

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[1] The ALJ's order indicates that Exhibits 1 through 38 and 31A were admitted into evidence. At hearing, Exhibits 13A, 16A, 17A, 24A, 26A, 26aA, 34A, 34B and 34C were also admitted into evidence (Tr. 1), and the revised exhibit list indicates that Exhibit 15A was admitted. We modify the ALJ's order to include those additional exhibits.

The first medical report referring to right shoulder symptoms after claimant's August 31, 1996 was on December 18, 1996, when claimant sought treatment from Dr. Hanes. (Ex. 5).

Claimant has the burden of proving compensability of his right shoulder injury. ORS 656.266. In light of claimant's failure to report any right shoulder symptoms to his physicians until almost three months after the August 31, 1996 injury, we are not persuaded that he sustained a right shoulder injury as a result of that accident. In sum, we conclude that claimant has failed to sustain his burden of proof, even under a material contributing cause standard.

ORDER

The ALJ's order dated May 29, 1998 is affirmed.

November 12, 1998 Cite as 50 Van Natta 2195 (1998)

In the Matter of the Compensation of
RICHARD PERLE, Claimant
WCB Case No. 97-09641
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its partial denial of claimant's current right epicondylitis condition. In his respondent's brief, claimant contends that the ALJ's assessed attorney fee of $2,750 should be increased. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the relevant facts. Claimant, a truck driver, developed pain in his right elbow, for which he sought medical treatment in April 1996. In July 1996, SAIF, as insurer for claimant's Oregon employer, accepted claimant's diagnosed right lateral epicondylitis as a compensable injury. Claimant's employer eventually laid him off, but claimant apparently began working for an unidentified California employer as a truck driver in September 1997, at which time he sought treatment for an exacerbation of his epicondylitis. (Ex. 29). The exacerbation resulted from a "re-tear" of a muscle at the lateral epicondyle level caused by his recent work activities in California. (Ex. 36 - 18 through 19).

On October 14, 1997, the Board approved a Claim Disposition Agreement (CDA) regarding the right lateral epicondylitis condition. The CDA provided that claimant released all benefits related to his right lateral epicondylitis claim, except for medical services, in exchange for a sum of money. (Ex. 30). Subsequently, on November 24, 1997, SAIF issued a partial denial on the ground that: "The April 3, 1996 injury is no longer the major contributing cause of your current condition and need for treatment to your RIGHT ELBOW EPICONDYLITIS." (Ex. 33). Claimant requested a hearing.

The ALJ found that SAIF's sole defense for denying the claim was that it was not responsible for claimant's current condition. Concluding that SAIF had not properly denied responsibility pursuant to ORS 656.308(2)(a) (requiring an insurer that disputes responsibility to advise the worker to file separate claims against other potentially responsible insurers), the ALJ cited *Garibay v. Barrett Business Services*, 148 Or App 496 (1997) and held that SAIF could not deny claimant's current condition claim. On review, SAIF argues that it was not required to issue a responsibility denial because claimant's subsequent work was for an out-of-state employer. For the following reasons, we uphold SAIF's denial.

To begin, because this dispute involves an "out-of-state" employer, we have serious doubts regarding the applicability of ORS 656.308. *See Progress Quarries v. Vaandering*, 80 Or App 160 (1986) (the claimant's Oregon carrier could not use the last injurious exposure rule defensively to shift responsibility to an out-of-state employment that was the last potentially causal employment prior to the onset of disability). Furthermore, we stated in *John J. Jett*, 46 Van Natta 33 (1994), that an "out-of-state" employer would not appear to be subject to Oregon laws and, thus, ORS 656.308 would not apply in "responsibility" disputes pertaining to an "out-of-state" employer. *See Miville v. SAIF*, 76 Or App 603, 607 (1985) (Oregon can apply its own rules consistently between Oregon employers); *Leonard C. Hobbs*, 46 Van Natta 171 (1994) (citing *Jett*). Therefore, we are not inclined to hold that SAIF was required to comply with the notification requirements of ORS 656.308(2)(a).

In any event, we need not resolve that question because SAIF denied "compensability." Specifically, SAIF denied the claim on the ground that claimant's compensable injury was no longer the major contributing cause of his current right lateral epicondylitis condition and need for treatment. (Ex. 33). SAIF was entitled to issue such a denial.

In *David E. Stutzman*, 50 Van Natta 776, *on recon* 50 Van Natta 889 (1998), we held that, where the carrier and the claimant were the only parties to the dispute and there was no attempt to shift responsibility to a prior carrier, the issue was compensability, rather than responsibility. We reasoned that, rather than conceding compensability of the claim and attempting to shift responsibility to a prior carrier, the carrier was availing itself of its statutory right to deny the claim under ORS 656.262(6) and to require the claimant to establish the compensability of his current condition and need for treatment.

Likewise, in this case, SAIF was availing itself of its statutory right to deny the claim under ORS 656.262(6). Claimant has requested a hearing concerning SAIF's compensability denial. Claimant has the burden of proving the compensability of his claim. ORS 656.266.

Wheeler v. Liberty Northwest Insurance Corporation, 148 Or App 301 (1997), assists us in resolving this case. There, the court affirmed our order in *Marilyn Wheeler*, 48 Van Natta 1082, *on recon* 48 Van Natta 1312 (1996), that had upheld an aggravation denial of the claimant's bilateral wrist, forearm, and elbow condition. Finding that the claimant's current condition constituted a "consequential condition" under ORS 656.005(7)(a)(A), we had concluded that the claim was not compensable because the claimant's accepted wrist tendinitis condition was not the major contributing cause of her current fibrositis and lateral epicondylitis condition. Although acknowledging that her subsequent work activities for an out-of-state employer had contributed to her current condition, the claimant contended that the condition was compensable because the accepted condition was a material contributing cause of her present disability. The claimant relied on *Miville*, 76 Or App at 604.

The court disagreed with the claimant's assertion. To the extent that the substantive rule from *Miville* retained any vitality in light of *amended* ORS 656.308(1) and *amended* ORS 656.273, the court determined that the rule was not applicable. The court noted that *Miville* concerned accidental injuries to the same body part, whereas *Wheeler* involved occupational diseases for different conditions. Moreover, because the claim concerned an unaccepted condition, the *Wheeler* court concluded that the claim must be analyzed either as a new injury or under the "major contributing cause" standard set forth in ORS 656.005(7)(a).

Reviewing for substantial evidence, the court held that we did not err in analyzing the claimant's current condition as a "consequential condition" under ORS 656.005(7)(a)(A) because uncontradicted evidence indicated that the claimant's pain was not directly caused by her accepted condition, but rather was causally related to her out-of-state work. Similarly, the *Wheeler* court agreed with our finding that there was insufficient evidence to establish that the claimant's accepted wrist tendinitis condition was the major contributing cause of her fibrositis and epicondylitis condition.

In this case, claimant sustained a "re-tear" of his epicondylitis condition as a result of his work activities in California. (Ex. 36-19). The medical evidence indicates that claimant's pain was not directly caused by his accepted condition, but rather was causally related to his out-of-state work. (Ex. 32). As we did in *Wheeler*, we analyze this claimant's current condition as a "consequential condition" claim under ORS 656.005(7)(a)(A). Claimant must, therefore, prove that his compensable elbow injury is the major contributing cause of his consequential elbow condition.

We agree with the ALJ that the medical evidence establishes that claimant's work activities for the out-of-state employer, not the original compensable injury, are the major contributing cause of the re-tear of the right lateral epicondylitis muscle. (Exs. 32, 35, 36-19, 36-20, 36-28).[1] Accordingly, claimant's current/consequential right elbow condition is not compensable. ORS 656.005(7)(a)(A); *Wheeler*, 148 Or App at 308. It follows that the ALJ's decision to set aside SAIF's denial must be reversed.

ORDER

The ALJ's order dated May 6, 1998 is reversed. SAIF's November 24, 1997 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[1] Although setting aside SAIF's denial under the *Garibay* rationale, the ALJ stated that, had he determined the merits of the denial, he would have found that claimant's work activities for the new employer in California were the major contributing cause of claimant's current condition and need for treatment. Opinion and Order Pg. 4 n. 2. We agree with the ALJ's evaluation of the medical record.

November 12, 1998 Cite as 50 Van Natta 2197 (1998)

In the Matter of the Compensation of
GORDON J. PUTNAM, Claimant
WCB Case No. 96-02423
ORDER ON REMAND
Doblie & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's November 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 the compensability of claimant's denied cervical condition.

Pursuant to the settlement, claimant stipulates that "his claim shall remain in its denied status and he shall receive no Workers' Compensation benefits on account of this cervical condition." The agreement further provides that claimant's hearing request "is hereby dismissed with prejudice."

We have approved the parties' settlement, thereby resolving their dispute.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

[1] Pursuant to OAR 438-009-0010(2)(g), a settlement must include a list of medical service providers who shall receive reimbursement in accordance with ORS 656.313(4), including the specific amount each provider shall be reimbursed, and the parties' acknowledgment that this reimbursement allocation complies with the reimbursement formula prescribed in ORS 656.313(4)(d). When no unpaid medical bills are in the carrier's possession on the date the settlement terms are agreed on, the "list" and "acknowledgment" requirements of OAR 438-009-0010(2)(g) are inapplicable. *See Robert E. Wolford*, 46 Van Natta 522 (1994).

Here, we note that the agreement includes claimant's acknowledgment that "he has treated for his condition and that there are no outstanding medical bills for medical prescriptions or treatment incurred prior to the agreement date of this settlement." Thus, in granting this approval, we have interpreted the aforementioned provision as the insurer's representation that it did not have any outstanding medical bills for claimant's cervical condition in its possession on the date the terms of the settlement were agreed on (October 8, 1998).

Finally, because the "Notice to All Parties" provision included on Page 4 of the agreement pertains to Claim Disposition Agreements and not to a Disputed Claim Settlement, the provision has been removed from the settlement.

In the Matter of the Compensation of
LARRY A. WARD, Claimant
WCB Case No. 98-01259
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that awarded 11 percent (35.2 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on September 6, 1995. He treated conservatively and was medically stationary on July 25, 1997. Dr. Kadwell, treating physician, performed a closing examination on September 19, 1997. Dr. Kadwell measured reduced lumbar range of motion and opined that the measurements were valid.

An October 14, 1997 Determination Order closed claimant's injury claim with a 19 percent unscheduled permanent disability award. Claimant requested reconsideration.

A medical arbiter examined claimant, reviewed his history, and measured his lumbar range of motion on January 21, 1998. A February 5, 1998 Order on Reconsideration reduced claimant's unscheduled permanent disability award to zero, based on the medical arbiter's report. Claimant requested a hearing.

The ALJ awarded claimant 11 percent unscheduled permanent disability, including 9 percent for lost lumbar range of motion. The ALJ relied on the medical arbiter's range of motion measurements, reasoning that the measurements were valid because the doctor did not provide an understandable written opinion explaining why the measurements were invalid. *See* OAR 436-035-0007(27).[1]

Claimant was medically stationary on July 25, 1996 and a Determination Order closed his claim on October 14, 1997. Therefore his claim is properly rated under WCD Admin. Order 96-027 (eff. February 15, 1997).

The medical arbiter measured claimant's lumbar range of motion with an inclinometer, recorded his findings, and responded to specific questions posed by the Appellate Unit. He opined that neither his nor Dr. Kadwell's inclinometer tests were validated because claimant's straight leg raising was much greater than his sacral motion. (Ex. 26-4-5; *see* Ex. 20[2]). Concerning causation, the arbiter stated:

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[1] The rule provides, in pertinent part, that

"findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid."

[2] Dr. Kadwell opined that all claimant's range of motion measurements were valid. (*See* Ex. 19). However, we note that Dr. Kadwell did not complete Sections 3g, 3h, and 3i of the "Spinal Range of Motion" form according to the form's instructions. Apparently, the doctor entered claimant's midsacrum lumbar flexion measurements rather than his total midsacrum measurements (*i.e.*, flexion *plus* extension) and, therefore, incorrectly concluded that claimant's straight leg raising was equal to or within 10 degrees of his maximum midsacral motion. (Ex. 20). Based on this error, we find that Dr. Kadwell's conclusion about the validity of claimant's measurements is not persuasive, at least insofar as the "straight leg raising validity check" results were inaccurate.

"In regard to the accepted condition of lumbar disc, I could not find any evidence of significant nerve root irritation or neurological deficit that would go along with a true radiculitis or nerve root compression. This man does have some degenerative changes in his back, which could lead to chronic back pain, and he has some functional interplay here, because of his markedly positive Waddell's, his unilateral positive Marxer's, and his nonvalidation on inclinometer testing, which indicates that there is significant subjective magnification." (Ex. 26-5).

In addition, responding to an inquiry about the invalidity of "any findings," the arbiter stated, "I do not feel that the inclinometer findings are valid for rating, because of [] positive Waddell's, positive Marxer's on the right, and lack of localizing neurological findings." (Ex. 26-6, *see* Ex. 26-3).

In our view, the arbiter supported and explained his conclusion that claimant's findings are either invalid or unrelated to his compensable condition. We also find that the arbiter's reasoning is based on sound medical principles, including the results of tests that he performed. *See* OAR 436-035-0007(27) (*see* n.1, *supra*). Accordingly, we conclude that claimant has not established entitlement to permanent disability compensation for injury-related impairment. *See Lorenza Melendez*, 49 Van Natta 1057 (1997).

ORDER

The ALJ's order dated July 13, 1998 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

November 12, 1998 Cite as 50 Van Natta 2199 (1998)

In the Matter of the Compensation of
CRAIG J. WOOD, Claimant
Own Motion No. 97-0410M
OWN MOTION ORDER
REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's August 13, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from October 3, 1997 through January 28, 1998. The employer declared claimant medically stationary as of January 28, 1998.

In an October 15, 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 October 21, 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 a carrier'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 issue 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, claimant states that "I feel that there is a disability issue to be addressed due to my surgery, in addition to the time loss compensation that has already been paid. I am requesting a final closing exam by Dr. Bald to determine my disability level at this time."

On April 1, 1998, Dr. Bald, claimant's treating physician, submitted an 828 form declaring claimant medically stationary as of January 28, 1998. Dr. Bald also noted claimant was released to regular work on January 5, 1998. On June 15, 1998, these observations were further confirmed when Dr. Bald concurred with a June 1998 insurer-arranged medical examination report that found claimant medically stationary. These opinions are unrebutted.

Thus, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed and that he is not entitled to additional temporary disability beyond January 28, 1998. We, therefore, conclude that the employer's closure was proper.

Alternatively, claimant's request could also be interpreted as seeking other workers' compensation benefits in addition to temporary disability benefits. Insofar as claimant is requesting further permanent disability in this claim, we are without authority to grant such an award. 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).[1]

Accordingly, we affirm the employer's August 13, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Finally, to the extent that claimant is seeking a directive from us requiring a "final closing exam" from Dr. Bald, we note that Dr. Bald has previously concurred with an IME report regarding claimant's medically stationary status. Thus, even if we were authorized to require a closing exam, we would not exercise that authority because Dr. Bald's concurrence with the IME effectively constitutes a closing exam.

In the Matter of the Compensation of
MARIE OSTIN, Claimant
WCB Case No. 98-00576
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) dismissed claimant's request for hearing regarding unpaid medical bills related to her accepted head contusion; and (2) upheld the self-insured employer's partial denial of claimant's headache condition. Claimant renews her request for penalties based on unpaid medical bills. On review, the issues are jurisdiction, compensability and penalties. We affirm.

FINDINGS OF FACT

The employer accepted claimant's injury claim for a February 16, 1997 nondisabling head contusion. On September 10, 1997, the employer issued an "Updated Notice of Acceptance at Claim Closure" that acknowledged acceptance of a head contusion and stated, "If you feel that your claim should also cover other conditions, please contact us[.]"

On January 6, 1998, the employer issued a partial denial, stating that claimant's "current headache condition and need for treatment is no longer the result of your original injury claim filed for a head contusion on 2/26/97." (Ex. 24). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At the outset of the hearing, claimant stated that she was contesting the employer's *de facto* denial of medical treatment for headaches under the accepted "head contusion" claim. (Tr. 3). She also acknowledged that the denial referenced "headaches" as a condition different from the contusion. (Tr. 5).

The ALJ ruled that the issue of medical expenses under the accepted claim was a matter outside the Hearings Division's jurisdiction, citing *SAIF v. Shipley*, 326 Or 557 (1998). The ALJ also upheld the employer's partial denial of claimant's current headache *condition* on the merits.[1] We agree and adopt the ALJ's opinion and conclusions. *See Billy I. Rumpel*, 50 Van Natta 207, 209 (1998) ("To the extent that claimant is asserting a 'new medical condition' for a consequential headache condition, the Hearings Division would have jurisdiction[.]").

ORDER

The ALJ's order dated June 4, 1998 is affirmed.

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[1] Claimant also argues that her October 1997 headache treatment bills should be paid because the partial denial of headaches is limited by its terms to claimant's headache condition as of the date of the denial and it may not be read to deny "pre-denial" medical services, citing *Tattoo v. Barrett Business Service*, 118 Or App 348 (1993). The employer responds that only *prospective* denials are impermissible under *Tattoo*, not *retrospective* denials. We agree with the employer.

In the Matter of the Compensation of
FRED R. COUNTRYMAN, Claimant
WCB Case No. 98-03020
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
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 affirmed an Order on Reconsideration that reduced the award of unscheduled permanent disability in a Notice of Closure from 22 percent (70.40 degrees) to zero. On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but with the following modification and supplementation. The ALJ's finding that the April 14, 1998 Order on Reconsideration did not award unscheduled permanent disability is modified to state that the reconsideration order eliminated claimant's award of 22 percent unscheduled permanent disability granted by the November 27, 1997 Notice of Closure. Finally, we supplement the ALJ's findings to reflect that Dr. John Takacs signed his wife's (Dr. Joan Takacs') November 3, 1997 letter to the SAIF Corporation. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the April 14, 1998 Order on Reconsideration that eliminated claimant's 22 percent award of unscheduled permanent disability. In doing so, the ALJ concluded that there was no persuasive evidence that claimant suffered permanent impairment due to his compensable February 13, 1997 low back injury, accepted as a lumbosacral strain.

On review, claimant contends that the award of permanent disability in SAIF's Notice of Closure should be reinstated because the medical opinion of Dr. John Takacs, whom he alleges was his attending physician at claim closure, established the presence of permanent impairment due to the compensable injury. For the following reasons, we find that claimant is entitled to reinstatement of his permanent disability award.

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 that the medical arbiter, Dr. Ballard, did not provide the most persuasive medical opinion addressing claimant's permanent impairment. In his March 14, 1998 examination, Dr. Ballard diagnosed degenerative disc disease at L4-5 and L5-S1 and a lumbosacral strain. Dr. Ballard, however, did not believe any of his physical examination was valid for rating of impairment. (Ex. 14-5). Dr. Ballard stated:

> "Due to inconsistencies in his [claimant's] physical examination, I have to assume that his lumbosacral strain has now resolved and that his current complaints are due, entirely, to his preexisting condition. Once again, this is stated because of the significant functional overlay and non-organic findings that I found during this examination, making all findings invalid." (Ex. 14-5, 6).

Despite Dr. Ballard's assumption that claimant's lumbosacral strain had resolved, we are not persuaded that the inconsistencies on examination necessarily mean that claimant no longer suffers from the effects of his compensable low back strain. While do not rely on any of Dr. Ballard's invalid impairment findings in evaluating claimant's permanent disability, we are unwilling to assume that claimant has no permanent impairment based solely on the fact claimant manifested inconsistencies in the arbiter's examination. Because Dr. Ballard provided little explanation for his assumption that claimant's compensable injury had resolved, we do not find that he has provided the most thorough and well-reasoned evaluation of claimant's permanent impairment. Rather, we find the November 3, 1997 joint report from Dr. John Takacs and Dr. Joan Takacs sufficient to constitute a preponderance of evidence establishing a different level of impairment.

We first note that the ALJ found that Dr. John Takacs was claimant's attending physician at claim closure and, thus, was the only other physician besides Dr. Ballard who could rate impairment. Dr. John Takacs opined that claimant had low back impairment that was entirely due to the compensable injury based on his belief that claimant had no preexisting low back condition. (Ex. 8A). The ALJ, however, discounted Dr. John Takacs' report because the record indicates that claimant had preexisting low back problems.

Yet, Dr. John Takacs signed and concurred with a later report submitted by his wife that evaluated the impact of claimant's preexisting low back condition, but still concluded that the compensable injury was the major contributing cause of claimant's disability. (Ex. 9). In addition, both doctors adopted the findings of a physical capacities evaluation (PCE) that documented reduced range of motion in claimant's low back. Both doctors also emphasized that the PCE findings were valid despite a positive straight leg raising validity test.[1]

Because the November 3, 1997 report of the Drs. Joan and John Takacs is thorough and well-reasoned, and because it adopts the findings of the PCE, we conclude both that claimant had permanent impairment due to the compensable injury and that the PCE range of motion findings should be used in rating permanent impairment. We now proceed with that rating.

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 November 26, 1997. Therefore, the standards in Workers' Compensation Department Administrative Order 96-072, effective February 15, 1997, apply to determine claimant's disability. OAR 436-035-0003(2) and (3).

The PCE indicates that claimant has 38 degrees of flexion, 4 degrees of extension, 10 degrees of left lateral flexion and 6 degrees of right lateral flexion. This equals 17 percent impairment. OAR 436-035-0360(19-21). The figure is reduced to reflect the Takacs' report that 25 percent of claimant's disability is the result of claimant's preexisting low back condition. Thus, 12.75 or 13 percent impairment is due to the compensable injury.

Claimant was 45 years old at claim closure and has 12 years of education. Claimant is entitled to value a of 1 for the age factor, but no value for education. OAR 436-035-0290(2); 436-035-0300(2)(a). In addition, claimant has an SVP of 2 based on the job providing the highest SVP number during the 5 years prior to the time of determination (DOT 850.683-030). OAR 436-035-0300(3). Therefore, the age and education total is 3.

With respect to adaptability, based on a comparison of the strength demands of claimant's job at the time of injury (medium) with claimant's maximum residual functional capacity (light), claimant is entitled to an adaptability factor of 3. OAR 436-035-0310(6). Multiplying the age/education value (3) times the adaptability factor (3), the product is 9. When added to the impairment value of 13, the sum is 22. Therefore, claimant's unscheduled permanent disability is 22 percent. Accordingly, we affirm the Notice of Closure's unscheduled award.

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[1] Although the ALJ determined that Dr. John Takacs was claimant's attending physician at claim closure, we need not determine whether the ALJ was correct. That is, both Dr. John Takacs and Dr. Joan Takacs signed the November 3, 1997 report. Therefore, it does not matter which physician was the treating doctor at claim closure because both doctors agreed with the reasoning in the November 3, 1997 letter, which adopted the findings in the PCE.

Because we have reinstated the unscheduled permanent disability awarded by the Notice of Closure, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. *See* ORS 656.386(2); OAR 438-015-0055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd Volk v. America West Airlines*, 135 Or App 565 (1995).

ORDER

The ALJ's order dated July 30, 1998 is reversed. In lieu of the April 14, 1998 Order on Reconsideration, the November 26, 1997 Notice of Closure is reinstated and affirmed. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order, not to exceed $3,800. In the event that this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in *Jane A. Volk*.

In the Matter of the Compensation of
GRACIELA KASPRZYK, Claimant
WCB Case No. 97-03018
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Mannix, Nielsen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's October 2, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Partial Disputed Claim Settlement Stipulation and Order as to Denial of Current Conditions," which is designed to resolve all issues raised or raisable between them.

Pursuant to the settlement, claimant agrees that the self-insured employer's denial "shall remain in full force and effect and shall become final." The agreement further provides that "claimant hereby withdraws any and all requests for hearing in this case," which the parties stipulate "shall be dismissed with prejudice as to all issues raised or which could have been raised."

We have approved the parties' settlement, thereby resolving their dispute.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In granting this approval, we note that the parties have incorporated into their settlement a "civil supplement," which pertains to claimant's employment status. As expressly recognized by the parties, their "civil supplement * * * is not subject to approval by the Board." Indeed, because our statutory authority is limited to matters concerning a claim arising under ORS chapter 656, our approval of the parties' settlement is limited to such matters and does not extend to issues involving claimant's employment, reemployment, or reinstatement.

In the Matter of the Compensation of
TAT HUENG, Claimant
WCB Case No. 97-09754
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that set aside as premature an Order on Reconsideration and Determination Order that closed claimant's claim for a contusion and strain of the thoracolumbar back and abdomen. On review, the issues are premature closure and, if the claim was not closed prematurely, extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured her back and abdomen on March 20, 1997. She was released for regular work on May 5, 1997 and did not seek further treatment. At that time, Dr. Sheedy projected that claimant would be medically stationary within 5-7 days. (Ex. 10). Claimant did not return to Dr. Sheedy after this visit.

On June 12, 1997, the insurer wrote to claimant advising that current medical information indicated that her compensable condition was medically stationary. (Ex. 13). On July 2, 1997, the employer advised claimant that it was planning to obtain administrative closure of the claim because she had not sought treatment for more than 30 days. The letter asked claimant or her physician to respond within two weeks, otherwise the employer would assume that she had completely recovered. (Ex. 15).

By letter dated July 7, 1997, claimant's counsel responded that claimant had not recovered and would be seeking further treatment. The letter also requested that the claim not be administratively closed. (Ex. 16). Thereafter, on July 21, 1997, claimant sought treatment from a new physician, who indicated on the "First Medical Report" (form 827) that claimant was not medically stationary. (Ex. 17).

On July 25, 1997, having not yet received the July 21, 1997 medical report, the insurer requested administrative closure on the basis claimant was presumed medically stationary. On August 5, 1997 the Department issued a Determination Order finding that the claim qualified for closure on June 4, 1997 pursuant to OAR 436-030-0034. (Ex. 22). Claimant requested reconsideration.

Claimant was seen by Dr. Woodward for a medical arbiter exam on October 22, 1997. (Ex. 27). The arbiter did not specifically address claimant's medically stationary status, but found that claimant had reduced motion of the thoracic and lumbar spine. The arbiter also determined that claimant's lumbar flexion and extension findings were invalid using the straight leg raising test.

On reconsideration, the appellate reviewer determined that claimant was medically stationary because she did not seek treatment for more than 30 days after her May 5, 1997 visit to Dr. Sheedy. The reviewer rated claimant's valid range of motion findings and, pursuant to a November 3, 1997 Order on Reconsideration, claimant was awarded 10 percent (32 degrees) unscheduled permanent disability. (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contended that her claim was prematurely closed. Alternatively, claimant contended that if the claim was properly closed, she was entitled to an additional 5 percent unscheduled permanent disability. The ALJ found that although the insurer's administrative closure was procedurally proper, the claim was nevertheless prematurely closed because claimant was not medically stationary at the time of the August 4, 1997 Determination Order.

On review, the insurer argues that the administrative closure was proper, that claimant was medically stationary as of June 4, 1997 and that the claim was not closed prematurely. In response, claimant contends that she was not medically stationary at the time of claim closure. Alternatively, claimant argues that if the claim closure was not premature, she is entitled to an additional 5 percent for loss of extension of the lumbar spine.

For the reasons set forth below, we conclude that the administrative claim closure was proper under ORS 656.268(1)(b) and OAR 436-030-0034 (WCD Admin. Order 96-052). We further find that, insofar as the claim closure was authorized under ORS 656.268(1)(b), we need not decide whether claimant was medically stationary at the time of closure.

Pursuant to ORS 656.268(1)(b), a claim can be closed without the worker's condition being medically stationary where the worker fails to seek medical treatment for 30 days without the attending physician's instruction or approval unless the worker affirmatively establishes that the failure to seek treatment is attributable to reasons beyond his or her control. OAR 436-030-0034(1)[1] similarly allows claim closure when the worker is not medically stationary if the worker has not sought treatment for a period in excess of 30 days without the attending physician's instruction or approval for reasons within the worker's control, so long as the insurer has sent proper notification to the worker and given the worker 14 days to respond before any further action is taken towards claim closure.[2]

In this case, claimant does not contend that her failure to seek treatment for two and a half months after her May 5, 1997 visit to Dr. Sheehy was due to reasons beyond her control. Rather, she asserts that, by virtue of her attorney's July 7, 1997 response to the insurer's notice and/or her July 21, 1997 visit to the Rockwood clinic, the administrative closure should be set aside as substantively inappropriate because she was not medically stationary. We disagree.

ORS 656.268(1)(b) clearly and unequivocally provides that a claim may be closed even if the worker is not medically stationary so long as certain specified conditions are met. Those conditions have been met in this case. Claimant failed to seek treatment for a period in excess of 30 days without the approval of her attending physician. Upon receiving appropriate notice from the insurer and an opportunity to respond, claimant did not affirmatively establish that her failure to seek treatment was attributable to reasons beyond her control.[3] Therefore, as the ALJ found, the administrative closure was procedurally valid under ORS 656.268(1)(b).

Although we have previously indicated that the merits of a premature closure issue remain irrespective of the procedural closure issue, *see Mark E. Cooper*, 47 Van Natta 2223, 2224 n.3 (1995), we have yet to squarely address whether a valid administrative closure pursuant to OAR 656.268(1)(b) necessarily precludes a worker from proving on the merits that the claim was prematurely closed because he or she was not medically stationary at the time.[4] *See, e.g. David M. Chandler*, 48 Van Natta

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[1] The rule provides, in pertinent part, as follows:

"(1) A claim may be closed by the insurer or Department when the worker is not medically stationary and the worker has not sought medical treatment for a period in excess of 30 days, without the instruction or approval of the attending physician, for reasons within the worker's control; and

"(a) The insurer has notified the worker, by certified letter, that claim closure will result for failure to seek medical treatment for a period of 30 days. The notification letter shall inform the worker of the worker's responsibility to seek medical treatment in a timely manner, and shall inform the worker of the consequences for failing to do so, including claim closure.

"(b) Workers shall be given 14 days to respond to the certified notification letter before any further action is taken by the insurer towards claim closure."

[2] As the ALJ found, claimant does not contend that the administrative closure was improper because the insurer's notification letter was invalid. *Compare Martha E. Leyva*, 49 Van Natta 1177 (1997) (where the insurer failed to strictly comply with OAR 436-030-0034(4), Board found the administrative closure improper).

[3] Indeed, claimant did not even assert that her failure to seek treatment in the two months following her May 5, 1997 appointment was due to reasons beyond her control.

[4] We acknowledge that, in his dissenting opinion in *Mark E. Cooper*, Member Hall took the position that a properly implemented administrative closure does not foreclose a claimant from proving on the merits that he or she was not medically stationary at claim closure, but this does not represent a majority opinion.

1500 (1996) (noting that our statement in *Mark E. Cooper* regarding the merits of the premature closure issue was dicta, and that the fundamental issue in *Cooper* was whether the record was adequately developed to determine whether the procedural closure was proper). Now that we are presented with the issue, we conclude, based on the following analysis, that a claimant may not negate a valid administrative closure pursuant to ORS 656.268(1)(b) with evidence that he or she was not medically stationary.

Like subsections (a) and (c) of ORS 656.268(1), subsection (b) provides a specific exception to the rule that "claims shall not be closed if the worker's condition has not become medically stationary."[5] As noted above, this provision expressly authorizes closure of the claim when the worker is *not* medically stationary if the worker fails to seek treatment for a period in excess of 30 days without the attending physician's approval or fails to attend a closing examination, unless the worker can show that such failure was due to reasons beyond his or her control. In other words, all three subsections of ORS 656.268(1) presume that the claimant is not medically stationary, and set forth other factors and/or conditions that, if established, nevertheless qualify the claim for closure.

Moreover, after considering the text and context of ORS 656.268(1)(b), we find nothing to indicate that a valid claim closure under this section can be set aside by a showing on the merits that the worker is, in fact, not medically stationary. Indeed, even assuming that the clear and unequivocal terms of the statute could be considered ambiguous, we find nothing in the legislative history of ORS 656.268(1)(b) to suggest that the legislature intended that this provision constitutes only a "rebuttable presumption" that the worker is medically stationary.[6] *Cf. Mark E. Cooper*, 47 Van Natta at 227 (Member Hall, concurring in part and dissenting in part). Consequently, in this case, we decline to consider claimant's July 21, 1997 medical report as evidence that her claim was prematurely closed.

Having determined that claimant's claim was validly closed pursuant to ORS 656.268(1), we address the extent of claimant's permanent disability. On review, claimant renews her contention that she is entitled to an additional 5 percent unscheduled permanent disability (above the 10 percent awarded by the Order on Reconsideration) based on the arbiter's findings relating to loss of lumbar extension. We disagree.

The only evidence in the record concerning the extent of claimant's permanent disability due to her compensable injury comes from the medical arbiter. With regard to the lumbar spine, Dr. Woodward found that claimant had 46 degrees maximum true flexion; 8 degrees maximum true extension; 10 degrees maximum right lateral flexion; and 16 degrees maximum left lateral flexion. Dr. Woodward noted, however, that both the lumbar flexion *and* extension measurements were not valid, based upon the straight leg raising test validity check. (Ex. 27-3). Insofar as Dr. Woodward expressly invalidated claimant's lumbar extension measurements and explained the basis for his determination, claimant is not entitled to a permanent disability award for this finding. *See Teri S. Callahan*, 49 Van Natta 548, 549 (1997) (the validity of range of motion testing must be determined by the medical examiner performing the tests); *see also Manuel Villa-Gallegos*, 49 Van Natta 1386 (1997) (the claimant failed to prove impairment where the medical arbiter stated range of motion measurements did not satisfy straight leg raising validity criteria). Consequently, we reinstate the Order on Reconsideration awarding claimant 10 percent unscheduled permanent disability.

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[5] ORS 656.268(1)(a) allows for claim closure when the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition and the worker is not enrolled and actively engaged in training. ORS 656.268(1)(c) allows for claim closure when the worker is enrolled and actively engaged in training according to the administrative rules.

[6] ORS 656.268(1)(a) and (b) were enacted in 1995 as part of SB 369. In discussing subsection (b), Jerry Keene testified that it is "a procedural provision about when the worker fails to seek treatment for more than 30 days unless it's because the doctor told them not to. Subsection B clarifies then that in that situation that worker can be deemed medically stationary and a closure can go ahead." (Tape 49, side A).

Although prior to the enactment of ORS 656.268(1)(b) the administrative rule, *former* OAR 436-30-035(7), provided that a worker would be presumed to be medically stationary if he or she failed to seek treatment for a period in excess of 28 days, neither the statute nor the current administrative rules refer to any presumption of medically stationary status. Rather, both expressly allow claim closure "when the worker is not medically stationary." Consequently, we believe that the dissent's position, *i.e.*, that an administrative closure under this section is based on a presumption that the worker is medically stationary, is inconsistent with the current statutory language.

ORDER

The ALJ's order dated April 15, 1998 is reversed. The November 3, 1997 Order on Reconsideration and the August 5, 1997 Determination Order are reinstated and affirmed.

Board Member Moller specially concurring.

I agree with the majority that the administrative claim closure in this case was valid and appropriate under ORS 656.268(1)(b). I write separately, however, because I would alternatively find that, on the merits, claimant was medically stationary at the time of claim closure.

"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, based on competent medical evidence. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981); *Harmon v. SAIF*, 54 Or App 121, 125 (1981).

In this case, claimant's accepted injury is a contusion/strain of the left thoracolumbar spine and left abdominal wall. On May 5, 1997, three months prior to the August 5, 1995 Determination Order, Dr. Sheedy released claimant for regular work and indicated that claimant would be medically stationary within 5 to 7 days. Dr. Sheedy also noted that there was no need for claimant to return for treatment unless she experienced further problems.

Claimant did not seek treatment for two and a half months. On July 21, 1997, however, she presented to Adventist Health, complaining of left side and lower back pain. Diagnosing a "possible back strain," the examining physician recommended heat and Advil.[1] The physician released claimant to regular work with no further examination or treatment scheduled, noting that claimant's condition could be rechecked when she "returned as needed" ("P.R.N.").

Although the physician indicated on the form 827 that claimant was not medically stationary, I would not find this unexplained, "check-the-box" notation to be persuasive, particularly in light of Dr. Sheedy's prior opinion and the examining physician's other observations. Indeed, consistent with Dr. Sheedy's May 1997 report, the July 1997 examining physician did not recommend further treatment and released claimant to regular work without qualification. Consequently, on this record, I would conclude that claimant has not affirmatively established that she was not medically stationary at the time of the August 5, 1997 Determination Order.

Finally, in response to the dissent's contention that the majority's interpretation of ORS 656.268(1)(b) effectively leaves a worker without compensation in those circumstances where the medical evidence otherwise would satisfy the requisites for reinstating temporary disability benefits (*see* dissent, footnote 3), I note that, in the same vein, where a claim is administratively closed when the worker's condition is not medically stationary, the carrier risks paying permanent disability on a condition that may well improve over time. I submit, however, that the statutory scheme for such administrative closures reflects a legislative judgment with which we should not tamper.

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[1] The examining physician's signature is not legible, and his or her name is not apparent from the record.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that the administrative closure of this claim pursuant to ORS 656.268(1)(b) and OAR 436-030-0034 (WCD Admin. Order 96-052) was proper. I also dispute the majority's reasoning that claimant is precluded from establishing that her compensable condition was not medically stationary at the time of claim closure. Consequently, I respectfully offer this dissenting opinion.

Although the carrier initially mailed claimant a "failure to seek medical treatment" letter, the eventual basis for its request to the Evaluation Section for claim closure was that "current medical information indicates [claimant's] compensable condition is medically stationary." (Ex. 19). In light of such circumstances, I would find that the carrier relinquished its original basis for threatening claim closure. Thus, it was improper for the Evaluation Section to close the claim based on OAR 436-030-0034 as was recited in the Evaluator's Worksheet. Because the sole basis for the closure was claimant's alleged "medically stationary" status and because the medical evidence establishes that her compensable condition was not medically stationary, I am persuaded that the claim was prematurely closed.

Alternatively, even if the "failure to seek treatment" basis was considered, I would reject the premise that the claim was properly closed. The carrier's "pre-closure" letter to claimant expressly stated that it would "assume" that claimant had completely recovered unless claimant or her physician responded within two weeks to the carrier's July 2, 1997 letter. Because claimant (through her counsel) responded on July 7, 1997 (stating that claimant had not recovered and would be seeking further treatment), the "assumption" proposed by the carrier's July 2, 1997 letter had been timely rebutted. Inasmuch as the procedural premise for the administrative closure was invalid (*i.e.*, the basis for the carrier's "medically stationary" assumption had not been satisfied), I would find the closure of the claim to have been improper.

Although I believe that the administrative closure of the claim was procedurally invalid for the reasons previously expressed, I also disagree with the majority's conclusion that claimant is barred, as a matter of law, from proving that her compensable condition was not medically stationary at the time of claim closure. I base my position on the following reasoning.

As set forth in the majority opinion, ORS 656.268(1)(b) and OAR 436-030-0034(1) authorize claim closure even if the claimant is not medically stationary if the worker fails to seek medical treatment for 30 days without the attending physician's approval, unless the worker affirmatively establishes that the failure to seek treatment is attributable to reasons beyond his or her control. As the Board explained in *Mark E. Cooper*, 47 Van Natta 2223, 2224 n.3 (1995), "the merits of a premature closure issue remain irrespective of the procedural closure issue." *See also David M. Chandler*, 48 Van Natta 1500 (1996). In other words, as discussed at length in Member Hall's concurring and dissenting opinion in *Mark E. Cooper*, although the validity of the procedural closure must be addressed before reaching the merits of the claimant's contention that the claim was prematurely closed, *see Paniagua v. Liberty Northwest Corp.*, 122 Or App 288 (1993), the substantive closure issue remains notwithstanding the application of ORS 656.286(1)(b). In simplest terms, ORS 656.268(1)(b) is a mechanism for claim closure (among others); it is not an ultimate, unchallengable determination of the substantive merits of the claim. The majority's reading of the statute creates a single class of closures from which there would be no administrative review of the substantive merits. I can find no legislative intent for such an outcome from the plain language of the statute. Indeed, even if "legislative history" from one witness was considered, that "history" reveals that the amended law was aimed at "closure" of the claim, not as a bar to the review of the merits of the claim closure.

Unlike the majority, as previously expressed in Member Hall's dissenting opinion in *Cooper*, an administrative closure, even if properly implemented, does not preclude a worker from proving on the merits that his or her claim was prematurely closed. An administrative closure pursuant to ORS 656.268(1)(b) is based only on the presumption[1] that the worker is medically stationary and that, to the extent a worker can rebut the presumption (by presenting evidence that he or she was not medically stationary at claim closure), the claim closure may be set aside on substantive grounds.

ORS 656.268(1)(b) does not provide that the worker is considered medically stationary when the specified conditions are met. Rather, the definition of "medically stationary" remains unchanged: "that no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). Because the ORS 656.268(1)(b) does not expressly deem a claimant medically stationary as a matter of law when the conditions set forth therein are satisfied, I would construe the provision as merely a procedural mechanism for closing the claim but not a substantive bar to addressing the merits of the premature closure issue.[2] Consequently, even where the claim is

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[1] The majority offers criticism of the use of this notion of "presumption." It should be understood that my use of the term is in the same sense that an administrative finding or determination is accepted as true unless the moving party presents legally sufficient evidence to convince the reviewing body that the finding or determination is not so. In this regard, I would treat review of all "medically stationary" determinations the same.

[2] In this respect, this administrative closure is not unlike the "reasonable cooperation" provisions of ORS 656.262(15) in that, following a Director's finding of a worker's failure to reasonably cooperate with a claim investigation, the worker's benefits, as well as the carrier's claim processing obligations, will be suspended. Following the worker's cooperation or an ALJ's order overturning a "non-cooperation" denial, however, the suspension of benefits is lifted and the carrier's claim processing obligations are restored.

properly closed under ORS 656.268(1)(b), I believe that a claimant is nevertheless entitled to prove that he or she was not medically stationary at the time of closure.[3]

Here, although the claim was closed under ORS 656.268(1)(b) pursuant to an August 5, 1997 Determination Order, claimant went to the Adventist Health Clinic on July 21, 1997. At that time, the examining physician specifically indicated on the First Medical Report that claimant was not medically stationary and that it was undetermined whether permanent impairment would result. Considering this affirmative indication that claimant was not medically stationary as of July 21, 1997 and, in the absence of any evidence to the contrary, I agree with the ALJ that claimant has proven that her claim was prematurely closed. Consequently, I would affirm the ALJ's order.

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[3] As in other premature closure cases, it remains the claimant's burden to prove that he or she was not medically stationary on the date of closure. *See Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). This issue is primarily a medical question to be decided on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981).

As a practical matter, where a claim has been administratively closed based on a claimant's failure to seek medical treatment, a claimant attempting to establish that she was, in fact, not medically stationary will encounter significant procedural and substantive evidentiary hurdles. To begin, in requesting reconsideration of the claim closure, the claimant will need to present medical evidence to support a conclusion that her compensable condition was not medically stationary at closure. In light of the time limitations surrounding the reconsideration proceeding, garnering such evidence may be a difficult process. Moreover, considering that the claim was already closed based on the claimant's failure to remain in contact with her physician, the probative weight of such medical evidence (assuming that it can even be produced in time for presentation during the reconsideration proceeding) may well be discounted (whether the evidence is presented for temporary or permanent disability purposes).

Finally, and most troubling, the majority's interpretation of the statutory scheme erects a system which effectively leaves this worker without compensation even though she satisfies the requisites for entitlement to temporary disability benefits. In other words, although the medical evidence establishes that claimant's compensable condition was not medically stationary at claim closure, the majority's holding precludes her from overturning that closure and prevents the reinstatement of her temporary disability benefits. Furthermore, because the future reopening of this now closed claim is premised on an "actual worsening" of her compensable condition since the last award or arrangement of compensation (ORS 656.273(1)), proof that her compensable condition was not medically stationary at claim closure will likely be inadequate to establish a compensable aggravation claim.

In the Matter of the Compensation of
ANTONIO LARA, Claimant
WCB Case No. C8-02497
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Alan L. Gallagher, Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Bock and Moller.

On November 4, 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.

Enclosed with the CDA is a "Fee Agreement" signed by claimant and his attorney. The CDA makes no reference to this "agreement." To the contrary, the CDA provides for an attorney fee of $1,400, payable from the $5,600 in CDA proceeds. Inasmuch as the "Fee Agreement" has not been incorporated into the CDA, and provides for an attorney fee contrary to OAR 438-015-0052(1), the "Fee Agreement" has not been considered in our review of the CDA. Because the attorney fee included in the CDA is consistent with the Board's attorney fee rule, the CDA has been approved.

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

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

IT IS SO ORDERED.

November 16, 1998 Cite as 50 Van Natta 2211 (1998)

In the Matter of the Compensation of
ROBERT R. RAMSEY, Claimant
WCB Case Nos. 98-00904 & 97-03499
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Stoel Rives LLP, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld the SAIF Corporation's responsibility denial of a "new injury" claim for a right wrist condition; and (2) declined to assess a penalty against American Cemwood Corporation for its alleged failure to timely process an aggravation claim. American Cemwood cross-requests review of those portions of the ALJ's order that: (1) set aside its responsibility denial of claimant's current right wrist condition; and (2) upheld SAIF's responsibility denial of the same condition. On review, the issues are responsibility and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant injured his right hand while working for American Cemwood in September 1994. American Cemwood accepted a right scaphoid fracture. (Ex. 7). On June 8, 1995, Dr. Dodds performed surgery on the right scaphoid nonunion. (Exs. 12, 15). He performed a second surgery on claimant's right wrist in February 1996. (Ex. 46). Claimant was declared medically stationary on March 28, 1996. (Ex. 51).

In March 1996, claimant began working for SAIF's insured as a heavy equipment operator and mechanic. (Tr. 11). In late November 1996, he injured his right wrist while removing a wheel-bearing locknut on a trailer axle. (Ex. 57). He sought medical treatment from Dr. Dodds on January 13, 1997. (Ex. 55). Dr. Dodds reported that claimant had a scaphoid nonunion and he recommended surgery. (Ex. 56).

SAIF denied responsibility on April 11, 1997 and requested a paying agent. (Ex. 65). American Cemwood denied responsibility on March 17, 1998. (Ex. 68). An order designating a paying agent was issued on March 19, 1998. (Ex. 70).

The ALJ analyzed the claim under ORS 656.308(1) and determined that claimant had not sustained a new injury for which SAIF was responsible.

On review, the parties agree that ORS 656.308(1) applies to this case. Under ORS 656.308(1), American Cemwood remains responsible for future compensable medical services and disability relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition." When a worker sustains a second injury to the same body part, the subsequent employer is responsible only if the second injury constitutes the major contributing cause of the worker's disability or need for treatment for the combined condition. *SAIF v. Britton*, 145 Or App 288, 292 (1996).

There are three medical opinions on causation. In evaluating the medical evidence, we rely on those opinions that are well-reasoned and based on accurate and complete histories. *See Somers v. SAIF*, 77 Or App 259 (1986). Claimant and American Cemwood rely on Dr. Dodds' opinion to argue that claimant's November 1996 work injury at SAIF's insured was the major contributing cause of his current right wrist condition. For the following reasons, we agree with their contention.

After claimant's first injury at American Cemwood, Dr. Dodds performed a closing examination in March 1996 and reported that claimant would likely experience waxing and waning of his residual symptoms. (Ex. 51-2). He noted that it would be beneficial for claimant to avoid repetitive and/or extremely strenuous usage of the right hand and wrist as much as possible. (*Id.*)

On February 20, 1997, Dr. Dodds reported that claimant had experienced a "specific acute significant injury" to the wrist in November 1996. (Ex. 60-1). He felt that claimant's recent injury was the major contributing cause of his current need for treatment. (Ex. 60-2). He explained that claimant had previously been able to successfully return to fairly strenuous usage of the hand and wrist with only minor reactive symptomatology. (*Id.*)

In a later report, Dr. Dodds said that claimant had a preexisting scaphoid fibrous nonunion that combined with the November 1996 injury to cause the need for treatment. (Ex. 67-1). He explained that after the closing exam in March 1996, claimant had tolerated rather stressful usage of the hand and wrist without difficulty. (*Id.*) He acknowledged that claimant had some waxing and waning of residual symptoms, but was doing quite well with minimal symptomatology. (*Id.*) Dr. Dodds felt that, although it appeared that claimant had a fibrous nonunion of the scaphoid, the nonunion was a stable one that had allowed satisfactory usage of the wrist with minimal complaints before November 1996. (Ex. 67-2). He concluded that the November 1996 injury was the major contributing cause of claimant's current need for treatment. (*Id.*)

We are persuaded by Dr. Dodds' opinion because it is well-reasoned and based on complete information. He evaluated the relative contribution of claimant's preexisting condition, but nevertheless determined that the work injury at SAIF's insured was the major contributing cause of claimant's need for medical treatment for his current right wrist condition. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

For the following reasons, we are not persuaded by the opinions of Drs. Strukel or Mayhall. Dr. Strukel performed a records review on behalf of SAIF and concluded that claimant's preexisting condition was the major cause of his current treatment and disability. (Ex. 62-5). We find that Dr. Strukel's opinion was based on an inaccurate history. Dr. Strukel was under the impression that a "halo" had appeared on the radiographs within one month of the November 1996 injury. (Ex. 62-3). Dr. Strukel asserted that the halo effect takes many months to form and was not a direct result of the November 1996 injury. (Ex. 62-4). However, Dr. Strukel's understanding of the date of the radiographs was incorrect. The radiographs were not taken until mid-January 1997. In fact, Dr. Mayhall acknowledged that the November 1996 injury could have caused the "halo" formation that appeared in January 1997. (Ex. 64-9). Because Dr. Strukel's opinion was based on an inaccurate history, it is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977).

Dr. Mayhall examined claimant on one occasion. He felt that after March 1996, claimant had a fibrous union and not a true solid union of the scaphoid. (Ex. 64-8). He concluded that the major contributing cause of claimant's current condition was the preexisting condition, although he acknowledged a "significant contribution" from the work activities. (Ex. 64-8, -9).

We are more persuaded by Dr. Dodds' opinion. Dr. Dodds responded that, even if claimant had a fibrous nonunion, the nonunion was "stable" and had allowed him the stressful use of his hand and wrist for nearly seven months after the March 1996 closing examination. (Ex. 67). In sum, based on Dr. Dodds' opinion, we conclude that claimant's November 1996 work injury at SAIF's insured was the major contributing cause of the need for medical treatment for his current right wrist condition. Consequently, SAIF is responsible for claimant's condition.

Claimant also contends that he is entitled to a penalty against American Cemwood for its alleged failure to timely process his aggravation claim. Because we agree with the ALJ that there is no evidence in the record to establish when American Cemwood received the claim, we cannot say that the denial was untimely. *See Darren E. Conklin*, 50 Van Natta 459 (1998).

At hearing, the ALJ awarded claimant's attorney a $2,500 attorney fee, payable by American Cemwood. On review, we have found SAIF solely responsible for claimant's current right wrist condition. Accordingly, SAIF shall pay the attorney fee awarded by the ALJ. After consideration of the factors set out in OAR 438-015-0010(4), we find the $2,500 fee for counsel's services at hearing to be reasonable.[1]

ORDER

The ALJ's order dated May 26, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside American Cemwood's responsibility denial of claimant's right wrist condition is reversed. American Cemwood's denial is reinstated and upheld. The portion of the ALJ's order that upheld the SAIF Corporation's responsibility denial of claimant's right wrist condition is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. The ALJ's attorney fee award is payable by SAIF, rather than American Cemwood. The remainder of the ALJ's order is affirmed.

[1] Because this case arises under ORS 656.307, claimant is not entitled to an attorney fee award for his counsel's services on review. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994).

November 17, 1998 Cite as 50 Van Natta 2213 (1998)

In the Matter of the Compensation of
JUDY SMITH, Claimant
WCB Case No. C8-02331
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven T. Maher, Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On October 15, 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, number 21, provides that the parties agree to waive the 30-day cooling off 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. Inasmuch as the 30-day "cooling off" period has expired, we have proceeded with our review.

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.

November 17, 1998 Cite as 50 Van Natta 2214 (1998)

In the Matter of the Compensation of
CHERYL A. VIRTUE, Claimant
WCB Case Nos. 98-01828 & 97-06528
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorneys

Claimant requests reconsideration of our October 23, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld the insurer's denial of her cervical condition as directly related to her November 1989 work injury; (2) upheld the insurer's denial of her cervical condition as a consequence of her accepted low back condition; and (3) upheld the insurer's denial of her cervical condition as an occupational disease claim. Specifically, claimant asserts that the ALJ's findings are not supported by substantial evidence and that we erred in not addressing whether she had a compensable cervical condition at any time between November 1989 and the present, as opposed to determining the compensability of her current condition only.

To begin, we briefly recap the pertinent facts: In November 3, 1989, while working as a grocery check-out clerk, claimant experienced the onset of low back, left leg and hip pain as she lifted a 50-pound bag of dog food from the floor into a customer's cart. She completed an 801 form asserting that she had suffered a "strained back" and sought chiropractic treatment. Dr. Hartwell, D.C., diagnosed a left SI strain/sprain and released claimant from work for about a week. By mid-November 1989, claimant had returned to her regular work, albeit with lifting restrictions. The insurer accepted a disabling left sacroiliac sprain/strain.

Between November 1989 and early February 1990, claimant treated with Dr. Hartwell approximately 22 times. On February 28, 1990, claimant was examined by Drs. Isaacson and Burke at the insurer's request. Drs. Isaacson and Burke noted that claimant's chief complaints were left low back pain and occasional left shoulder and neck pain. They diagnosed a left SI joint strain and a left neck strain "compensatory to the low back pain."

Claimant continued to treat with Dr. Hartwell through June 1990. At that time, he declared her medically stationary, but noted that she still experienced occasional low back, shoulder and neck pain. Claimant's claim was closed pursuant to a July 2, 1990 Notice of Closure, which awarded temporary disability and 4 percent unscheduled permanent disability for the low back.

In August 1990, claimant began treating with Dr. Mitchell, who approved palliative chiropractic care for her ongoing low back symptoms. Dr. Mitchell continued to follow claimant and approve palliative care for her lumbar and thoracic symptoms through 1995. During this five-year period, claimant's primary complaint was low back pain, although she occasionally complained of neck pain.

In January 1996, claimant was examined by Dr. Strum at the insurer's request. He diagnosed persistent low back pain of undetermined etiology. In August 1996, claimant returned to Dr. Mitchell complaining of cervicothoracic pain. In February 1997, claimant reported continued back pain and some tingling in her hands. Dr. Mitchell recommended a MRI of the cervical spine, which showed a left paracentral disc protrusion at C4-5 and disc bulging at C5-6 with neural foraminal narrowing.

On April 29, 1997, claimant's counsel requested that the insurer accept claimant's neck condition as a consequence of her compensable low back injury. The insurer declined to do so. On November 7, 1997, claimant's counsel requested formal written acceptance of claimant's neck condition pursuant to ORS 656.262(6)(d), asserting that the condition had been incorrectly omitted from the original notice of

acceptance. Thereafter, claimant filed an 801 form, alleging that her neck condition constituted an occupational disease related to her work activities for the employer. The insurer denied that claimant's neck condition had been incorrectly omitted from the original notice of acceptance and also that her work activities were the major contributing cause of her neck condition.

As set forth above, the ALJ determined that claimant had not established the compensability of her cervical condition as directly related to the November 1989 work incident, as a consequence of her accepted low back injury or as an occupational disease. By adopting and affirming the ALJ's order, we found that the ALJ's order correctly applied the law and reached the appropriate result under the facts presented in the record. *See e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997) (by adopting an ALJ's order, the Board agrees with the facts and conclusions contained in the ALJ's order and considers the ALJ's order to be sufficient for appellate review). Consequently, we disagree with claimant's first contention that the ALJ's findings are not supported by the evidence.

Claimant's second contention merits further discussion, however. In upholding the insurer's denials, the ALJ declined to consider whether claimant had a compensable neck condition in 1990, noting that no claim was made for the condition at that time. Claimant contends that, insofar as ORS 656.262(7)(a) authorizes a worker to initiate a "new medical condition" claim *at any time,*[1] she did not have to make a claim for her neck condition in 1990. In other words, claimant asserts that, if the medical evidence establishes that she sustained a neck strain in 1990 as either a direct result of, or a consequence of, her accepted 1989 low back injury, she is entitled to pursue the insurer's acceptance of that condition at any time.

Assuming (without deciding) that under the current statutory scheme claimant may now assert a new or consequential medical condition claim for a condition she may have had in 1990,[2] we nevertheless find, for the reasons set forth below, that claimant has not established the compensability of this condition by a preponderance of the evidence.

Claimant argues that she sustained a neck strain either as a direct result of the November 3, 1989 incident itself or as a consequence of her accepted low back strain. We note, however, that Dr. Hartwell, who treated claimant on numerous occasions beginning in November 1989, did not identify any specific injury to her neck. Dr. Hartwell diagnosed a severe left SI sprain/strain due to the work incident, but did not diagnose any neck or cervical condition. Similarly, Dr. Mitchell, who began treating claimant in August 1990, did not diagnose any neck condition at that time. He took a history of claimant having felt pain in her low back while lifting a heavy bag of dog food, but did not refer to any neck pain arising from the incident during this time.

Although Dr. Hartwell's chart notes document claimant's periodic complaints of neck and left shoulder pain in the months following the lifting incident, we find this evidence insufficient to establish a compensable causal relationship between claimant's neck pain and the November 3, 1989 work incident. Indeed, in this regard, we are persuaded by the assessment of Dr. Strum, who, after eliciting a description of the lifting incident from claimant, opined that the mechanism of injury was not consistent with a neck strain or a musculologamenous injury to the cervical region.

To support her alternate theory that she sustained a neck strain as a consequence of the accepted low back strain, claimant cites to the February 1990 report of Drs. Isaacson and Burke, who diagnosed a left neck strain "compensatory to" her low back pain. To establish such a consequential condition, claimant must prove that her accepted low back strain was the major contributing cause of her neck condition. *See* ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). The

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[1] This section provides, in pertinent part, that "[n]otwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time." Similarly, ORS 656.262(6)(d) authorizes a worker to initiate an objection to a notice of acceptance "at any time," when the worker believes that a condition has been incorrectly omitted from the notice or that the notice is otherwise deficient.

[2] Claimant argues that, under ORS 656.262(7)(a), a claim may be submitted at any time, "even long after a claimed condition may have ceased to be related to the accepted claim." (Request for Reconsideration at pp. 3-4).

determination of "major contributing cause" involves evaluating the relative contribution of different causes of an injury and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994). Because Drs. Isaacson and Burke do not explain their use of the term "compensatory to," and do not evaluate the relative contribution of other causes for claimant's neck pain, we find their report insufficient to establish a compensable consequential condition. Moreover, neither Dr. Hartwell nor Dr. Mitchell (who both had the opportunity to evaluate claimant on many occasions) documented any neck strain related to claimant's accepted low back condition during this time. Consequently, we conclude that claimant has not established the compensability of her 1990 neck condition by a preponderance of the evidence.

We withdraw our October 23, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our October 23, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. BENJAMIN, Claimant
Own Motion No. 98-0376M
OWN MOTION ORDER
Welch, Bruun, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable fourth metatarsal fracture, right foot injury. Claimant's aggravation rights expired on June 20, 1993. SAIF issued a denial of the compensability of claimant's current left foot's second and fourth metatarsal head-plantar keratoses requiring condylectomies on the second and fourth toes condition on September 14, 1998. Claimant has not appealed that denial. In addition, SAIF opposes authorization of temporary disability compensation, contending that: (1) it is not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability.

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

Here, the current left foot's second and fourth metatarsal head-plantar keratoses requiring condylectomies on the second and fourth toes condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MYA L. LAND, Claimant
WCB Case No. 97-03617
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of findings 5 and 14.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's low back condition that developed after she spent four or five hours bussing tables as a hostess in the employer's restaurant. Analyzing the claim as an accidental injury, the ALJ determined that claimant's injury had combined with a preexisting low back condition to cause disability and a need for treatment. *See* ORS 656.005(7)(a)(B). The ALJ found, however, that claimant had failed to sustain her burden of proving that work activities were the major contributing cause of her need for treatment or disability. Although both the attending physician, Dr. Scurlock, and Dr. Daven, who examined claimant at the request of the insurer, related claimant's back condition to her work activities, the ALJ found their opinions unpersuasive because neither doctor had a complete and accurate history.

On review, claimant contends that Dr. Scurlock's and Dr. Daven's medical opinions satisfy her burden of proof. In particular, claimant challenges the ALJ's finding, based on a physical therapy chart note, that she previously experienced episodes of low back pain that radiated into her buttocks and upper thighs. Claimant asserts that the chart note is ambiguous and does not support the ALJ's factual finding. This point is important because Dr. Daven based his opinion that claimant's work activities were the major contributing cause of her back condition in part on claimant's report that she had never previously experienced such symptoms. (Ex. 18-5).

The record is clear that claimant had a preexisting low back condition. We agree with the ALJ that Dr. Scurlock's opinion that claimant's back pain was "work-related" is not persuasive because he did not have this history. (Ex. 10-A-2); *See Somers v. SAIF*, 77 Or App 259 (1986); *William D. Brizendine*, 50 Van Natta 21 (1998) (physician's opinion unpersuasive without accurate and complete history). On the other hand, Dr. Daven was aware that claimant had prior back problems, which included a fractured coccyx. (Ex. 18-3, 5). Dr. Daven, however, opined that claimant's work was the major contributing cause of her back condition because her pain after the January 11, 1997 injury was more severe and she had never before experienced radiation of pain into the buttocks and legs. (Ex. 18-5). The dispositive issue is whether Dr. Daven's history regarding the radiating symptoms was correct.

The basis for the ALJ's finding that claimant previously experienced pain in the buttocks and leg is the physical therapy chart note of January 23, 1997. (Ex. 3). In it, the physical therapist reported that claimant developed lower back pain on January 11, 1997 bussing tables and that: "With this episode she had more radiating discomfort than usual into her buttocks and upper thighs." While the ALJ was persuaded that this history established the presence of prior buttock and leg pain, we agree with claimant that the history is ambiguous. It could, as the ALJ found, mean that claimant experienced another episode of radiating pain in the buttocks and upper thigh. Or it could mean that claimant's discomfort was greater than usual and radiated into the buttocks and thigh.

We find some clarification later in the same report, where the therapist's chart note states: "Pt's present episode of more acute low back pain may have a disk component to it, especially with the radiation that she is noting to the buttocks and thighs." (Ex. 3-2). Although not dispositive, this

notation suggests that claimant's "present episode" of back pain was both more acute than prior episodes and involved a new component of radiation. Further, claimant testified credibly that, as a result of her January 11, 1997 work activity, her pain radiated into her legs and feet and that it had never previously done so. (Tr. 18, 20). Given this testimony, the ambiguity in the January 23, 1997 chart note, and the lack of other references in the record to prior buttock and lower extremity symptoms, we are unwilling to conclude that Dr. Daven's history was inaccurate.

Accordingly, based on Dr. Daven's opinion, which we find well-reasoned and persuasive, we conclude that claimant's work activity on January 11, 1998 was the major contributing cause of her low back condition, disability and need for treatment. Therefore, we find that claimant satisfied her burden of proving that a compensable low back injury occurred on January 11, 1997.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 28, 1998 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by the insurer.

November 18, 1998 Cite as 50 Van Natta 2218 (1998)

In the Matter of the Compensation of
TIMOTHY W. STONE, Claimant
WCB Case No. 97-06478
ORDER OF ABATEMENT
Bischoff, Strooband & Ousey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

On October 22, 1998, we found that claimant's right foot plantar fasciitis condition was compensable, assessed the SAIF Corporation a penalty for unreasonable claim processing, and awarded an insurer-paid attorney fee under ORS 656.386(1). Asserting that it has received notice that claimant died prior to our October 22, 1998 order and has no statutory beneficiaries to pursue the claim, SAIF seeks reconsideration of our decision and dismissal of claimant's request for review.

In order to further consider this matter, we withdraw our October 22, 1998 order. In addition, we implement the following supplemental briefing schedule. Claimant's counsel's response must be filed within 14 days from the date of this order. SAIF's reply must be filed within 14 days from the date of mailing of claimant's counsel's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
COLLEEN P. SMITH, Claimant
WCB Case No. 98-02546
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller 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 bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

The ALJ upheld SAIF's denial of claimant's bilateral CTS, finding that claimant failed to sustain her burden of proving that her work activity was the major contributing cause of a pathological worsening of a preexisting CTS condition. *See* ORS 656.802(2)(b). On review, claimant asserts that the opinion of her surgeon, Dr. Franks, establishes a pathological worsening of her bilateral CTS. (Ex. 27-2). We disagree.

At the outset, we agree with the ALJ that the current occupational disease claim is based on a worsening of a preexisting disease or condition. Dr. Youker diagnosed bilateral CTS in 1992 (Ex. 2-2). SAIF denied that condition on July 21, 1992. (Ex. 7). The denial was not appealed and became final. To establish the compensability of claimant's current occupational disease claim, claimant must prove that employment conditions are the major contributing cause of the combined condition and pathological worsening of the disease.[1] *See Dan D. Cone*, 47 Van Natta 1097, *on recon* 47 Van Natta 2220, *on recon* 47 Van Natta 2343 (1995).

Dr. Franks stated that claimant's work activities "influence[d] the generation of pressure within the carpal tunnel leading to demyelinization, slowing of conduction and clinically symptomatic carpal tunnel syndrome." (Ex. 27-2). Dr. Franks' comment, however, does not confirm that claimant's work activities pathologically worsened claimant's CTS. To the contrary, in the very same report, Dr. Franks stated that claimant's condition was "significantly related 51 % or more on a symptomatic basis" to job activities. (Ex. 27-1, emphasis in original). In prior reports, Dr. Franks also opined that claimant's work "very significantly worsened her symptoms" necessitating surgery, and that claimant's work activities made over a 51 percent contribution to "clinically significant carpal tunnel syndrome, i.e. the development of symptoms that ultimately required surgical management." (Exs. 22, 24, emphasis supplied).

Based on our *de novo* review of Dr. Frank's opinion, we are not persuaded that it establishes a pathological, as opposed to a symptomatic, worsening of claimant's bilateral CTS. Therefore, we agree with the ALJ's decision to uphold SAIF's denial.

ORDER

The ALJ's order dated July 24, 1998 is affirmed.

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[1] SAIF does not contend that the unappealed 1992 denial bars litigation of the current CTS claim.

In the Matter of the Compensation of
MIKE D. SMITH, Claimant
Own Motion No. 98-0107M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 2, 1998 Own Motion Order, which denied his request for reopening of his 1975 injury claim for the payment of temporary disability benefits because he failed to establish that he was in the work force at the time of the current disability.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666; *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

On March 4, 1998, the SAIF Corporation submitted its own motion recommendation opposing authorization of temporary disability compensation. SAIF contended that claimant had withdrawn from the work force at the time of his disability. A copy of SAIF's recommendation was also sent to claimant, along with a letter explaining the work force criteria.

On March 9, 1998, we requested the parties' positions regarding SAIF's "work force" contentions. We allowed 14 days from the date of the letter for the parties to respond. By April 2, 1998, having received no response from either SAIF nor claimant, we proceeded with our review.

Claimant did not respond to SAIF's work force contentions following its submission of the own motion recommendation or to our March 9, 1998 request. On April 2, 1998, we issued our order denying claimant's request for temporary disability benefits because the record did not establish that claimant was in the work force at the time of his current disability. Our order included a notice to the parties that if they were unsatisfied with our decision, they could seek reconsideration of our decision within 30 days from the date of the order.

Claimant's request for reconsideration was received by the board on October 21, 1998, more than 60 days after the issuance of our April 2, 1998 order. Submitting a copy of our April 2, 1998, claimant responded to "this letter" he received on October 7, 1998. We interpret claimant to mean that he first received a copy of our April 2, 1998 order on October 7, 1998 and, therefore, could not have sought reconsideration of our order within the 30 day appeal period.

Claimant does not explain why he may not have received our order in a timely fashion. However, we note that claimant's return address for his current "reconsideration" request is different from the address to which our April 2, 1998 order was mailed. As such, we might be inclined to find extraordinary circumstances to warrant our reconsideration under OAR 438-012-0065(2).

However, we need not resolve that procedural matter because, even if we considered claimant's belated submission, the record still does not support a conclusion that he was in the work force at the time of his disability. In his request, claimant refers to Dr. Becker's medical report (previously submitted to us by SAIF), which demonstrates that his condition worsened requiring surgery. Nonetheless, the report does not address claimant's "work force" status and, thus, does not support a conclusion that he was in the work force at the time of his current disability.

Claimant further asserts that he was willing to work and "seeking work through the State of Oregon OFF-SET Program." He does not provide any documentation to support his assertion. Without further corroboration and/or documentation, we consider claimant's unsworn assertion insufficient to demonstrate that he was in the work force at the time of his current worsening.

Accordingly, claimant's request reconsideration is denied.[1]

IT IS SO ORDERED.

[1] As claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

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

In the Matter of the Compensation of
BRIAN A. IVERSON, Claimant
WCB Case No. C8-02373
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Thomas A. Andersen, Defense Attorney

Reviewed by Board Member Bock and Haynes.

On October 19, 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 5, number 19, provides that the parties agree to waive the 30-day cooling off 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. Inasmuch as the 30-day "cooling off" period has expired, we have proceeded with our review.

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
JILL FERREN, Claimant
WCB Case No. C8-02532
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Dale C. Johnson, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

On November 6, 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.

Paragraph 7, on page 2 of the CDA provides: "The claim is currently in an open status and has never gone through closure. The parties stipulate that claimant's condition is medically stationary and is effectively closed without permanent impairment as of the date of this settlement."

We have held that it is impermissible for a CDA to accomplish claim processing functions, including claim closure, because it is not one of the objectives to be resolved with such an agreement. *E.g., Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992).

We do not interpret the present CDA, however, as attempting to impermissibly close the claim. Instead, because the CDA expressly provides that "[T]he claim is currently in an open status and has never gone through closure[.]," we interpret the agreement merely as stating that the claim has not been closed and no permanent disability benefits have been awarded.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KYMBERLY D. BROOKS, Claimant
WCB Case No. 97-06320
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of her occupational disease claim for right wrist conditions. On review, the issues are the propriety of the insurer's denial and compensability. We reverse.

FINDINGS OF FACT

Claimant, a collections agent, filed an occupational disease claim for a right wrist condition in March 1996. Dr. Glovinsky diagnosed right wrist tendonitis. Claimant was involved in a motor vehicle accident about two months after filing her claim. She reportedly jammed her right elbow into a car door. Dr. Glovinsky referred claimant to Dr. Kho, who diagnosed cumulative overuse tendonitis of the right hand, including right lateral epicondylitis and mild de Quervain's tendonitis. (Ex. 8-4).

On June 19, 1996, the insurer specifically accepted "right wrist tendonitis." An examining physician, Dr. Potter, evaluated claimant's condition shortly thereafter and diagnosed "clinical suggestion" of mild carpal tunnel syndrome, along with right wrist tendonitis. Dr. Potter opined that claimant's work was the major contributing cause of claimant's condition. (Ex. 10).

In September 1996, Dr. Lowengart became claimant's attending physician and diagnosed cumulative trauma that included de Quervain's tendonitis, mild carpal tunnel syndrome and lateral epicondylitis. (Ex. 13). On October 31, 1996, Drs. Nolan and Lowenstein examined claimant on the insurer's behalf. While Dr. Lowenstein's diagnoses were similar to Dr. Lowengart's, Dr. Nolan concluded that claimant had no diagnosable condition and that the major contributing cause of claimant's complaints was "psychogenic." (Ex. 17-4).

On May 16, 1997, claimant's attorney requested that the insurer accept the following conditions pursuant to ORS 656.262(6)(d): "carpal tunnel syndrome; right upper extremity; lateral epicondylitis; right upper extremity and de Quervain's tendonitis." (Ex. 31). After receiving additional information from Dr. Lowengart, the insurer responded on June 2, 1997 to the request to amend its acceptance. (Ex. 35). The insurer's claim's examiner stated: "At this time, I will not be amending my acceptance as her treating physician has determined that our accepted condition for a right wrist tendonitis is one and the same (as your requested conditions) and not required separate treatment." On July 31, 1997, claimant requested a hearing, raising the issues of "de facto" denial and failure to timely process the request for expanded acceptance.

The insurer later arranged another evaluation of claimant's right wrist condition, this time performed by Dr. Radecki on October 2, 1997. (Ex. 39). Dr. Radecki stated his examination pointed to very significant psychosocial stressors causing psychogenically-based regional pain syndrome or overt malingering. (Ex. 39-16). Dr. Radecki opined that the regional pain syndrome was not organic in nature and could only be explained by psychosocial stressors. (Ex. 39-18).

After a deposition of Dr. Lowengart, in which she defended her diagnoses and opined that the major cause of claimant's condition was her work activities (Ex. 41), the insurer denied bilateral carpal tunnel syndrome and lateral epicondylitis on November 21, 1997 on the ground that claimant's work activity was not the major contributing cause of these conditions. (Ex. 42). Furthermore, the insurer stated that the de Quervain's condition was contemplated in the acceptance of the right wrist tendonitis and that, therefore, a formal acceptance or denial was unnecessary. Claimant requested a hearing from the denial.

CONCLUSIONS OF LAW AND OPINION

At hearing, the issue was the propriety of the November 1997 denial. (Tr. 2). The ALJ rejected claimant's contention that the November 21, 1997 denial retroactively denied her claim for lateral epicondylitis, de Quervain's tendonitis, and carpal tunnel syndrome. The ALJ then upheld the insurer's

denial, finding that the conditions asserted to be compensable either did not exist, had already been accepted, or had not been proven work related.

On review, claimant again asserts that the November 1997 denial is a "back-up" denial of conditions she asserts were accepted in the insurer's June 2, 1997 letter. Moreover, claimant argues that the "back-up" denial is invalid because it was not based on "later obtained evidence." For the following reasons, we find claimant's arguments persuasive.

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

The requirement of "later obtained evidence" in ORS 656.262(6)(a) refers to new material, *i.e.*, something other than the evidence that the carrier had at the time of the initial acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286 (1993). A reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). *Id.*

The first step in our inquiry involves determining what conditions the insurer accepted. As previously noted, the insurer explicitly accepted right wrist tendonitis. The insurer, however, in its June 2, 1997 response to claimant's May 16, 1997 objection to its acceptance notice, refused to amend its acceptance because claimant's physician indicated that the right wrist tendonitis was "one and the same" as claimant's requested conditions and had not required separate treatment. (Ex. 35). Like claimant, we interpret this response as a refusal to amend the Notice of Acceptance because carpal tunnel, lateral epicondylitis and de Quervain's tendonitis were encompassed within the accepted right wrist condition and, thus, a formal acceptance was not necessary. *See* ORS 656.262(7)(a). This response was, therefore, equivalent to stating that the disputed conditions were accepted.

On November 21, 1997, the insurer issued a denial in which it stated that work activity was not the major contributing cause of the carpal tunnel syndrome and lateral epicondylitis. Furthermore, the insurer asserted that a formal acceptance or denial of the de Quervain's condition was not required because it was "contemplated in the accepted condition of right wrist tendonitis." (Ex. 42). Because the de Quervain's condition was explicitly accepted in the November 21, 1997 denial letter (if not in the June 2, 1997 letter), the only two conditions in dispute on review are the denied carpal tunnel and lateral epicondylitis conditions. To support a denial of those previously accepted conditions, there must have been "later obtained evidence" that those conditions were not compensable. As previously noted, a reevaluation of known evidence, for whatever reason, is not "later obtained evidence" under ORS 656.262(6)(a). *Magnuson*, 119 Or App at 286.

The insurer contends that Dr. Radecki's opinion constituted later obtained evidence sufficient to support the November 1997 denial. We disagree. Prior to its June 2, 1997 letter, the insurer had obtained a medical report from Dr. Nolan, who concluded that claimant had no diagnosable condition and that the primary cause of claimant's complaints was "psychogenic." (Ex. 17-4). Dr. Nolan noted suboptimal effort on examination and either conscious or subconscious malingering. (Ex. 17-5). Dr. Radecki's October 2, 1997 report reached conclusions similar to Dr. Nolan's. Dr. Radecki also mentioned the possibility of malingering and concluded that there was no organic explanation for claimant's pain syndrome and that "psychosocial" stressors could only explain her symptoms. (Ex. 39-16).

Dr. Radecki's report, therefore, was essentially a reevaluation of claimant's unchanged "post-acceptance" condition, which does not constitute "later obtain[ed] evidence." *See Delores Loving*, 47 Van Natta 2079, 2081, *on recon* 47 Van Natta 2256 (1995). Because the insurer's "back-up" denial was not based on "later obtained evidence," we conclude that its denial was invalid under ORS 656.262(6)(a). Therefore, we reverse the ALJ's decision to uphold the denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the "back-up" denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at

hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 18, 1998 is reversed. The November 21, 1997 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by the insurer.

November 20, 1998 Cite as 50 Van Natta 2225 (1998)

In the Matter of the Compensation of
LISA M. BURT, Claimant
WCB Case No. 97-07198
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Wallace, Klor, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's current neck and back condition. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of claimant's aggravation claim for the same condition. The insurer also requests sanctions against claimant's attorney under ORS 656.390 for an allegedly frivolous argument on Board review. On review, the issues are scope of review, *res judicata*, compensability, aggravation and sanctions. We reverse in part, affirm in part, and decline to impose sanctions.

FINDINGS OF FACT

Claimant has preexisting medical conditions involving her neck and back, including cerebral palsy, right leg shortening and muscle atrophy, and frequent flare-ups of neck and back pain since she was involved in a motor vehicle accident (MVA) in October 1988. (Exs. 1, 3, 6, 7, 9). Dr. Bell, neurologist, has treated claimant's neck and back symptoms since July 1989.

Claimant's January 31, 1992 compensable injury occurred when she fell backward into a counter while pulling baggage off a belt. Dr. Bell diagnosed a cervical and thoracolumbar strain, and the insurer issued an acceptance of "cervical/thoracic" strain. (Exs. 17, 18, 19).

A January 19, 1994 Determination Order closed the injury claim with an award of 25 percent unscheduled permanent disability. At this time, claimant was released to her regular work, but experienced persistent pain and muscle spasms in her neck and back, along with pain and numbness in the legs and a shock like sensation up and down the entire back and around the entire body.

Claimant's symptoms persisted and worsened following claim closure. In February 1995, Dr. Bell noted new episodes of jerking in claimant's extremities with excessive movement or tiredness, shock like sensation in the lower extremities with compression of the mid back, and weakness in the upper and lower extremities. (Ex. 42, 43).

On September 18, 1996, claimant filed an aggravation claim. On November 11, 1996, Dr. Rosenbaum, neurosurgeon, evaluated claimant for the insurer. On December 6, 1996, the insurer denied the aggravation claim. By letter dated March 5, 1997, counsel for claimant requested that the insurer amend its initial acceptance of the injury claim to include a lumbosacral strain, as well as a cervical and thoracic strain.

Claimant then requested a hearing from both the aggravation denial, and an alleged "de facto" denial of the lumbosacral strain. Meanwhile, on May 13, 1997, claimant filed a second claim for aggravation based on Dr. Bell's chart notes of that date, which focus on claimant's complaints of radiating pain into the right leg and foot, with right leg atrophy and episodes of tonic contraction of the leg.

The parties then entered into a July 15, 1997 Stipulation and Order. Pursuant to that agreement, claimant agreed to withdraw the September 18, 1996 aggravation claim, and the insurer agreed to withdraw its denial of that claim, process the May 13, 1997 aggravation claim, and amend its notice of acceptance to include the lumbosacral strain. In addition, the stipulation expressly provided that "[i]t is the parties' intent that this settlement shall not have any preclusive effect beyond the agreements contained herein with regard to the further processing of this claim."

On August 6, 1997, Dr. Leonard, neurologist, evaluated claimant for the insurer. On August 22, 1997, the insurer issued a denial of the May 13, 1997 aggravation claim, and claimant's current need for medical treatment. This matter is presently before the Board pursuant to claimant's request for hearing from that denial.

CONCLUSIONS OF LAW AND OPINION

Scope of Review/*Res Judicata*

In her brief on review, claimant contends that the insurer's current condition denial is barred under the *res judicata* doctrine of "claim preclusion." The insurer responds that we should not address this *res judicata* issue because it was not raised at hearing. The record supports the insurer's assertion that claimant first raised the *res judicata* issue in her brief on review, and claimant does not challenge that assertion. Consequently, we agree that the issue is beyond the proper scope of our review and we decline to address it. *Accord Kenneth L. Devi*, 49 Van Natta 108 (1997) (ALJ properly declined to address a preclusion theory that was not raised on the record).[1]

Current Condition Denial

The ALJ set aside the insurer's current condition denial after concluding that claimant's injury continued to *materially* contribute to her current neck and back condition. See ORS 656.245(1)(a). In applying a material contributing cause standard, the ALJ reasoned that this case was not controlled by ORS 656.005(7)(a)(B). Under that provision, if claimant's compensable injury "combines *at any time* with a preexisting condition to cause or prolong disability or a need for treatment," the current combined condition is not compensable unless the injury is the *major* contributing cause of that condition and related need for treatment. (Emphasis supplied).[2]

On review, the insurer argues that claimant's current condition is attributable to a combining of her compensable injury and preexisting condition(s) within the meaning of ORS 656.005(7)(a)(B). Thus, the insurer asserts that claimant must establish causation under a "major contributing cause" standard which is not satisfied by the record in this case.

Because there is more than one potential causal factor for claimant's current condition, resolution of the compensability and aggravation issues involves complex medical questions that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Here, the record includes relevant medical opinions from Dr. Bell, neurologist (Exs. 66, 73, 75, 76, 79, 89, 90), Dr. Rosenbaum, neurosurgeon (Exs. 59, 77), and Dr. Leonard, neurologist (Ex. 85). Dr. Bell has been claimant's treating physician since 1989. Drs. Rosenbaum and Leonard examined claimant and reviewed her medical record at the insurer's request.

We first address the insurer's contention that compensability of claimant's current condition should be determined under the major contributing cause standard of ORS 656.005(7)(a)(B). The ALJ reasoned that this provision is not applicable because the insurer did not accept a combined condition,

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[1] *See also Christine M. Mulder*, 50 Van Natta 518 (1998) (Board declines to address issue preclusion argument not raised until closing argument); *Martha L. Ladd*, 49 Van Natta 791 (1997) (Board declines to address claim preclusion argument not raised at hearing).

[2] 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 or the need for treatment of the combined condition."

and the medical record at the time of the July 1997 stipulation did not establish a combined condition. But, pursuant to the express language of ORS 656.005(7)(a)(B), this provision applies if an otherwise compensable injury combines *at any time* with a preexisting condition to cause or prolong disability or a need for treatment. Thus, the applicability of ORS 656.005(7)(a)(B) is not controlled by the scope of the insurer's acceptance, or the medical record at the time of the July 1997 stipulation. After considering all of the admissible medical evidence in the record, we are persuaded that claimant's current condition is attributable to a combining of her compensable injury and one or more preexisting conditions.

In a June 3, 1997 opinion letter, Dr. Bell stated that claimant's preexisting cerebral palsy, October 1988 MVA, and 1992 work injury all contributed to her current condition. And in a November 18, 1997 chart note, Dr. Bell opined that cerebral palsy "is probably responsible for [claimant's] persistent difficulties in preventing her from effective healing." In addition, Dr. Rosenbaum opined that claimant's January 1992 injury was "superimposed" on the residuals of her preexisting cerebral palsy and 1988 MVA.

These statements support a finding of a combined condition. There is no persuasive contrary opinion.[3] We, therefore, conclude that the medical record establishes that claimant's current condition is a "combined condition" within the meaning of ORS 656.005(7)(a)(B).[4] Thus, claimant must establish that the 1992 injury remains the major contributing cause of the need for treatment of the current combined condition. We conclude that the medical record does not satisfy claimant's burden of proof on this issue.

The only opinion supporting claimant's position is from Dr. Bell, who asserted that the 1992 injury was the major contributing cause of claimant's current condition because she would not be experiencing her current level of symptoms if she had not had that injury. Dr. Bell further reasoned that, whereas cerebral palsy was a fixed problem that usually does not progressively deteriorate, claimant did not have significant interference with her ability to work until after the injury.

Drs. Leonard and Rosenbaum rendered contrary opinions that claimant's cerebral palsy and 1988 MVA are the major contributing cause of her current condition.[5] In particular, Dr. Rosenbaum explained that: individuals with cerebral palsy would have musculoskeletal discomfort of a relatively diffuse basis in the absence of any type of superimposed injury; the chiropractor providing treatment for the 1988 MVA opined that claimant's muscle spasm type symptoms were of a permanent nature and would require treatment over her lifetime; and claimant's current objective findings (including spasticity with increased muscle tone and pathologic stretch reflexes) were all related to the preexisting cerebral palsy.

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, we find persuasive reasons not to defer to Dr. Bell's opinion because it does not satisfy the requirements discussed in *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 321 Or 415 (1995). In particular, Dr. Bell's "but for" rationale does not establish that claimant's injury is the primary cause of her current condition, as

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[3] The only other relevant opinion on this issue is from Dr. Leonard, who opined that the injury "*might* still be contributing to claimant's current symptoms "to a small degree". This equivocal opinion does not establish a combined condition or a contrary finding.

[4] In reaching this conclusion, we reject claimant's contention that the insurer cannot issue a current condition denial because the record does not establish a change in circumstances or a change in causation since the February 1992 acceptance, the January 1994 PPD award, or the July 1997 amended acceptance. Claimant relies on *Harry L. Lyda*, 48 Van Natta 1300 (1996), *aff'd State Farm Insurance v. Lyda*, 150 Or App 554 (1997), and *Elsa S. Wong*, 48 Van Natta 444, 445 (1996). These Board decisions construe ORS 656.262(6)(c), which provides that an insurer's acceptance of a combined condition does not preclude a later denial of that condition "if the otherwise compensable injury ceases to be the major contributing cause" of the combined condition. ORS 656.262(6)(c) is not controlling in the present case, where the insurer has not accepted a combined condition.

[5] Dr. Leonard opined that claimant's current pain was chronic and primarily attributable to her preexisting cerebral palsy, with its related kyphoscoliosis, spastic paraparesis and hemiparesis, right leg shortening and muscle atrophy, and gait and balance disorder.

distinct from the precipitating cause. Moreover, other statements by Dr. Bell suggest that the cerebral palsy is the primary cause of claimant's current condition, including Dr. Bell's assertion in a September 5, 1997 opinion letter that "[t]he fact [claimant] does have cerebral palsy has been a major contributing factor in the delay and lack of recovery[.]" Finally, the contrary opinions of Dr. Rosenbaum and Leonard are consistent with claimant's documented medical history.

In summary, we conclude that claimant's current symptoms and need for treatment is attributable to a combined condition within the meaning of ORS 656.005(7)(a)(B), and that the medical record does not satisfy the major contributing cause test required under that provision. Accordingly, claimant has not established a compensable claim for her current neck and back condition, and we reverse the ALJ's contrary decision.

Aggravation

In her cross-request for review, claimant challenges the ALJ's decision to uphold the insurer's aggravation denial. In reaching that decision, the ALJ reasoned that the record did not establish an "actual worsening" within the meaning of ORS 656.273(1).

Two elements are necessary to establish a compensable aggravation: a compensable condition; and an "actual worsening." ORS 656.273(1). For the sake of argument, we assume that there has been an "actual worsening" of claimant's condition since claim closure. Nevertheless, we have concluded above that claimant's current neck and back condition is not causally related to her compensable injury. For this reason, we affirm the ALJ's ultimate decision to uphold the insurer's aggravation denial. Consequently, we need not address the ALJ's "actual worsening" analysis.

Sanctions

Finally, we deny the insurer's request for sanctions under ORS 656.390. Pursuant to that provision, the Board may impose an appropriate sanction if claimant's request for review was frivolous or was filed in bad faith or for the purpose of harassment. Here, the insurer requests sanctions for claimant's allegedly frivolous *res judicata* argument. Specifically, claimant argues that the July 15, 1997 Stipulation and Order created a "claim preclusion" bar to the insurer's current condition denial. *See Liberty Northwest Insurance Corp. v. Bird*, 99 Or App 560 (1989). The insurer contends that this argument is frivolous because the stipulation expressly provides that "this settlement shall not have any preclusive effect beyond the agreements contained herein with regard to the further processing of this claim." In response, claimant argues that this language does not apply to the insurer's current condition denial, as distinct from the aggravation denial.

Pursuant to ORS 656.390(2), "frivolous" means that the request for review is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. Here, we conclude that claimant's *res judicata* analysis is a colorable legal argument that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While we chose not to exercise our discretionary authority to address the *res judicata* issue, we cannot say that the argument was frivolous. In any event, claimant's other arguments on the merits of the current condition and aggravation claims are supported by substantial evidence and sufficiently developed so as to create a reasonable prospect of prevailing. Consequently, this record does not support a conclusion that claimant's *request for Board review* was frivolous. Accordingly, the assessment of sanctions against claimant's attorney under ORS 656.390 are not warranted.

ORDER

The ALJ's order dated March 27, 1998 is reversed in part and affirmed in part. The portion of the order that set aside the insurer's August 22, 1997 current condition denial is reversed, and that denial is reinstated and upheld. The ALJ's $2,800 assessed attorney fee is reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JEFF R. ELIZALDE, Claimant
WCB Case No. 98-01960
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that found claimant's claim for a cervical condition was time-barred under ORS 656.265(4). On review, the issue is timeliness of the claim and, in the event the claim is timely, compensability.

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

In February 1993, claimant injured his left shoulder in a motor vehicle accident. He underwent acromioplasty surgery on that shoulder in June 1993.

On July 31, 1995, claimant filed a claim for an alleged injury to his left shoulder. He sought treatment and was diagnosed with a left shoulder strain, related to his preexisting left shoulder condition. Claimant did not return to work following the July 31, 1995 incident. In August 1995, in the course of treating claimant's left shoulder symptoms, Dr. Groman also identified a cervical component, involving osteophytes at the C5-6 level, a right posterolateral disc protrusion at C5-6, left posterolateral disc protrusion at C4-5 and a small left posterior disc protrusion at C6-7.

Meanwhile, on August 11, 1995, the SAIF Corporation issued a denial of claimant's left shoulder claim, asserting that claimant's work activity was not the major cause. This denial was not appealed and became final by operation of law.

On July 2, 1997, claimant filed a claim for neck, bilateral arm and shoulder symptoms which he related to the July 31, 1995 work incident. He filed another claim for bilateral hand and arm symptoms on October 8, 1997, alleging a July 31, 1995 date of injury. SAIF did not respond to these latter two injury claims, and claimant requested a hearing alleging "de facto" denials.

The ALJ found, among other things, that claimant's 1997 claims were time-barred under ORS 656.265 because the alleged injury occurred more than a year prior (on July 31, 1995).[1] Claimant raises two challenges on review. First, claimant argues that the ALJ erred in analyzing the timeliness issue under ORS 656.265, because his claimed cervical condition represents an occupational disease which gradually developed over time, following the July 31, 1995 work incident. Specifically, claimant argues that he did not learn of his occupational disease and its alleged relationship to the work incident until December 1996, making his claims timely under ORS 656.807(1).[2] Alternatively, claimant asserts that

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[1] ORS 656.265(1) provides, in pertinent part, that notice of an accident resulting in an injury or death shall be given immediately and not later than 90 days after the accident. In addition, ORS 656.265(4)(a) provides: "Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and: (a) The employer had knowledge of the injury or death."

[2] ORS 656.807(1) provides as follows:

"All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

because he is making a claim for a worsened cervical condition resulting from the original injury, he need not comply with the timeliness requirements for an initial claim. As set forth below, we reject both arguments.

As a preliminary matter, we note that claimant has raised the occupational disease/timeliness theory for the first time on review. At hearing, claimant argued that his cervical condition resulted from an injury to his neck, allegedly occurring at work on July 31, 1995. (Tr. 3). Because claimant did not raise the occupational disease/timeliness theory at hearing, we are not inclined to consider it on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing); *see also Gunther H. Jacobi*, 41 Van Natta 1031 (1989).

Furthermore, even if we were to consider claimant's contention, we would nevertheless find that the ALJ properly analyzed the timeliness of claimant's current claims under ORS 656.265. Although claimant asserts that his neck condition gradually progressed and worsened over the course of two years, he also maintains that the condition resulted from a specific injurious event allegedly occurring on July 31, 1995. When the symptoms occur over a discrete, identifiable period of time, are unexpected and due to a specific activity or event, the condition is properly analyzed as an injury. On the other hand, when the symptoms are gradual in onset, not attributable to a specific activity or event, and due to an ongoing condition or state of the body, the condition is treated as an occupational disease. *See, e.g., James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982); *O'Neal v. Sisters of Providence*, 22 Or App 9, 16 (1975). Given claimant's assertion that his current cervical condition stems from a discrete, injurious event on July 31, 1995, we find that the claims were properly analyzed as injury claims, even though his condition subsequently worsened (while he was no longer working).

Finally, contrary to claimant's contention, he may not circumvent the limitations statutes for filing an initial claim by characterizing his current claims as presenting a new or worsened condition, when he does not have an accepted claim involving the July 31, 1995 incident. Indeed, both the aggravation and new medical condition statutes are premised on a prior accepted claim.[3] *See* ORS 656.262(7)(a), 656.273(1). But in the absence of an accepted claim, claimant is bound by the timeliness provisions of ORS 656.265 when making a claim for a new or worsened condition allegedly arising from a work-related incident.

ORDER

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

[3] ORS 656.262(7)(a) provides, in pertinent part that *"[a]fter claim acceptance,* a worker may initiate a "new medical condition" claim at any time. (emphasis added). Similarly, ORS 656.273 provides that "[a]fter the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury."

November 20, 1998 Cite as 50 Van Natta 2230 (1998)

In the Matter of the Compensation of
ALLEN COMAN, Claimant
WCB Case No. 95-12947
ORDER ON REMAND (REMANDING)
Richard M. Walsh, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. *Coman v. Corrections Department*, 327 Or 449 (1998). The Supreme Court has reversed the Court of Appeals opinion, 149 Or App 496 (1997) that had affirmed our prior order, *Allen Coman*, 48 Van Natta 1882 (1996), which had affirmed an Administrative Law Judge's (ALJ's) order that had: (1) denied claimant's motion to compel the SAIF Corporation to disclose certain inmates' medical records; and (2) upheld SAIF's denial of claimant's claim for tuberculosis (TB). Concluding that the requested records were not "absolutely undiscoverable" under ORS 179.495 and determining that there was a method by which an ALJ's discovery order could be enforced by a circuit court under ORS 656.732, the Court held that the ALJ

would have been in error to decline to order the disclosure of the relevant, requested records. Consequently, the Supreme Court has remanded to the Board with instructions to remand this case to the ALJ to "grant discovery of the requested medical records under such circumstances as the ALJ shall find to be appropriate."

In accordance with the Supreme Court's directive, this matter is remanded to ALJ Nichols for further proceedings consistent with the Court's opinion and this order.[1]

IT IS SO ORDERED.

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[1] With the express purpose "to assist the Board in formulating a discovery order pursuant to the Supreme Court's ruling," claimant has submitted a discovery procedure designed to "satisfy the need of the claimant." In response, SAIF asserts that the next step in the process is for the ALJ to consider claimant's request for a subpoena of records. In reply, claimant agrees that "the case should be sent to an ALJ for the issuance of subpoenas." In light of the Court's mandate, we refer the parties' submissions to the ALJ for consideration in conjunction with the Court's specific directive to "grant discovery of the requested medical records under such circumstances as the ALJ shall find to be appropriate."

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

On July 13, 1998, we withdrew our June 15, 1998 Order on Review that upheld the insurer's denial of claimant's right radial tunnel syndrome claim and set aside the insurer's denial of claimant's bilateral cubital tunnel syndrome claim. We took this action to consider claimant's contention that additional medical reports should be admitted into the record and the insurer's objection to that submission. The parties have since submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the settlement, claimant stipulates that the insurer's "denial of July 11, 1997, as well as claimant's current condition denial as recited [in the settlement] shall be affirmed." The parties further agree that claimant's hearing request, as well as all issues currently pending before the Board, "shall be dismissed with prejudice."

We have approved the parties' settlement, thereby resolving their disputes, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In accordance with OAR 438-009-0010(4)(b), the settlement includes a provision stating that claimant retains all of her rights to workers' compensation benefits under ORS 656.245, 656.273, 656.278, and 656.340 insofar as those rights are related to her originally accepted bilateral lateral epicondylitis and right medial epicondylitis. In light of the aforementioned provision, we consider a subsequent statement in the settlement (which states that "acceptance of this settlement means that no present or future compensation or medical benefits will be allowed under the Workers' Compensation Act as a result of this claim") to pertain to the denied claims expressly resolved in the settlement and not to claimant's originally accepted conditions.

In the Matter of the Compensation of
BETTY L. MARTINEZ, Claimant
WCB Case Nos. 96-01346, 96-00819 & 95-02012
THIRD ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On September 3, 1998, we withdrew our August 25, 1998 second Order on Remand, in which we adhered to our conclusion that Wal-Mart is the responsible employer for claimant's right carpal tunnel condition under the last injurious exposure rule (LIER). We took this action to consider claimant's request that we award a $4,000 attorney fee for counsel's services performed at the Court of Appeals and on remand before the Board. Having received the parties' respective positions, we proceed with our reconsideration.

Claimant's counsel is entitled to a reasonable attorney fee pursuant to ORS 6 56.308(2)(d) for active and meaningful participation in prevailing against Wal-Mart's responsibility denial. Except in cases involving "extraordinary circumstances," however, ORS 656.308(2)(d) limits claimant to a maximum cumulative attorney fee of $1,000 for services at all levels of litigation. *Liberty Northwest Insurance Corp. v. Gordineer*, 150 Or App 136, 141 (1997); *Tammy Locke*, 48 Van Natta 250 (1996).

We begin our analysis by reviewing the attorney fee awards previously made in this claim. The ALJ awarded claimant a $1,750 fee for prevailing against Wal-Mart's denial of her right carpal tunnel syndrome. Both compensability and responsibility were at issue at hearing. The ALJ, however, did not specify which portion of the attorney fee award was allocated for counsel's services regarding compensability and which portion was allocated to responsibility. No party contested the ALJ's attorney fee award during Wal-Mart's appeal of the ALJ's order.

On Board review, the only issue was responsibility for claimant's right carpal tunnel condition. We affirmed the ALJ's order finding Wal-Mart responsible. While we awarded an $800 attorney fee for counsel's services on review, we, too, did not specify under what statute our award was made. Wal-Mart requests that we retroactively allocate a portion of the prior attorney fee awards to the responsibility issue, thereby reaching the $1,000 limit. After considering Wal-Mart's request, we decline to apportion the ALJ's $1,750 attorney fee award for the right carpal tunnel syndrome between the compensability and responsibility issues.

As previously noted, compensability was litigated before the ALJ, who did not mention ORS 656.386(1) or ORS 656.308(2)(d). An attorney fee under ORS 656.386(1), however, is a "natural derivative" of an overturned compensability denial. *Terry R. Myers*, 48 Van Natta 1039 (1996); *Frank P. Heaton*, 44 Van Natta 2104, 2106 (1992). We find that a $1,750 fee represents a reasonable award under ORS 656.386(1) for setting aside the compensability denial of the right carpal tunnel condition.[1]

"Compensability" was technically at issue on review because the ALJ's order addressed compensability and because of our *de novo* review authority. *See Burton I. Thompson*, 48 Van Natta 866 (1996). Therefore, a portion of the attorney fee award for services on review was made pursuant to ORS 656.382(2). "Responsibility," however, was the only issue actually litigated. Considering that no arguments addressed compensability and claimant's counsel's services were devoted to the responsibility issue, we find that only $200 of the $800 fee was attributable to ORS 656.382(2). The remaining $600 was awarded for the responsibility issue under ORS 656.308(2)(d).

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[1] In declining Wal-Mart's request that we apportion the ALJ's attorney fee award, we note that no party raised an issue regarding the ALJ's attorney fee award until this request for reconsideration of our Order on Remand. Under these circumstances, we decline to exercise our discretion to apportion the attorney fee in the ALJ's order. *See Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994) (Board has discretion not to address issue raised for first time on reconsideration). By contrast, we will apportion the attorney fee awarded in our April 11, 1997 Order on Review, which was the subject of the court's remand and our subsequent remand orders (see discussion below). In other words, because this order essentially constitutes reconsideration of our initial Order on Review, and because this attorney fee issue did not arise until the issuance of that order, we consider it appropriate to exercise our discretion to reexamine the attorney fee granted in that order.

This leaves only $400 available for claimant's counsel's services regarding the responsibility issue before the court and on remand, because of the $1,000 limitation in ORS 656.308(2)(d). Based on our consideration of the factors set forth in OAR 438-015-0010(4), such as the time devoted to the case (as represented by the record, claimant's respondent's brief before the court and memorandum on remand), the complexity of the responsibility issue, and the value of the interest involved, claimant is awarded a $400 attorney fee for services before the court and on remand regarding the responsibility issue, payable by Wal-Mart. ORS 656.308(2)(d).

Claimant argues, however, that she is entitled to a fee greater than $1,000, based on "extraordinary circumstances." We disagree. The hearing took one and one-half hours to complete and generated 38 pages of transcript. Claimant was the only witness to testify. The documentary record consisted of 133 exhibits, including two depositions. Claimant, however, obtained only two medical reports which were primarily directed at the compensability issue. (Exs. 130, 131). Claimant submitted a brief of five pages on review and of slightly more than four pages to the court. In addition, claimant produced a one page memorandum on remand. The responsibility issue, while vigorously contested by the carriers, was not of a complexity substantially greater than that ordinarily encountered by the Board. Under these circumstances, we are not persuaded that "extraordinary circumstances" exist to justify a greater attorney fee award under ORS 656.308(2)(d).[2]

Accordingly, on reconsideration, we award claimant an additional fee of $400 pursuant to ORS 656.308(2)(d), payable by Wal-Mart. We otherwise adhere to and republish our August 25, 1998 order, with the clarification that, of our prior $800 attorney fee award, $200 was awarded pursuant to ORS 656.382(2) and $600 was awarded under ORS 656.308(2)(d). The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] Claimant did not contend that the case involved "extraordinary circumstances" at hearing, on review, before the court or on remand.

In the Matter of the Compensation of
CHARLOTTE M. SOROS, Claimant
WCB Case Nos. 97-08397 & 97-08299
ORDER ON RECONSIDERATION
Michael A. Bliven, Claimant Attorney
Lundeen, et al, Defense Attorneys

On October 21, 1998, we issued an Order on Review that: (1) denied claimant's motion to dismiss the insurer's request for Board review; and (2) reversed the Administrative Law Judge's (ALJ's) award of a $2,000 attorney fee pursuant to ORS 656.382(2). Contending that both of our determinations were erroneous, claimant seeks reconsideration of our decision and either dismissal of the insurer's appeal or an affirmance of the ALJ's order.

Relying on OAR 438-011-0005(2), claimant asserts that the insurer's request for Board review was jurisdictionally defective because the insurer neglected to simultaneously mail a copy of its request to claimant's attorney as required by the administrative rule. The purpose of this administrative directive is to attempt to insure that notice of a party's request for Board review is being provided to the other parties and their legal representatives in a timely manner. Although compliance with such a rule is certainly expected, the violation of such a requirement does not necessarily result in the dismissal of the appeal.

This is particularly the case, where, as here, the enabling statute expressly provides that "[c]opies of the request *shall be mailed to all parties in the proceeding before the Administrative Law Judge.*" *See* ORS 656.295(2). Considering the clear directive of ORS 656.295(2), we are not authorized to more narrowly define our jurisdiction. *See Leslie Thomas*, 43 Van Natta 1364 (1991); *Kimberly L. Murphy*, 41

Van Natta 847 (1989). Inasmuch as it is well established that "attorneys" are not considered "parties" (*Haskell Corporation v. Filippi*, 152 Or App 117 (1998) and *Berliner v. Weyerhaeuser Company*, 92 Or App 264, 266, n. 1 (1988)), it follows that the insurer's timely notice of its appeal to claimant is statutorily sufficient to vest appellate jurisdiction with this forum.

Alternatively, assuming for the sake of argument that notice of a request for Board review on a party's attorney is a jurisdictional prerequisite, the record supports a conclusion that claimant's counsel received actual notice within 30 days of the ALJ's order. As noted in our previous decision, the Board mailed a July 8, 1998 letter to all parties and their attorneys acknowledging a request for review. Because the ALJ's order issued on June 19, 1998 and because claimant's counsel concedes receipt of the Board's acknowledgment letter (albeit that he was apparently unaware of its existence until "well after 30 days from the date of the Opinion and Order"), we are persuaded that the Board's July 8, 1998 acknowledgment letter was received by claimant's counsel's office on or before July 18, 1998 (the 30th day from the ALJ's June 18, 1998 order). Such circumstances lead us to conclude that claimant's counsel was provided with actual notice of the existence of the insurer's request for Board review within 30 days of the ALJ's order. *See Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983); *Denise M. Bowman*, 41 Van Natta 1930 (1989); *John D. Francisco*, 39 Van Natta 332 (1987).

In conclusion, on reconsideration, we continue to reject claimant's argument that the insurer's request for Board review must be dismissed as jurisdictionally invalid. As explained above, our primary reason is that we are not authorized to insert a jurisdictional requirement that is not statutorily mandated. Secondarily, even if notice to a party's attorney is a jurisdictional prerequisite, the record supports a conclusion that claimant's counsel was provided with actual notice of the insurer's appeal within 30 days of the ALJ's order.[1]

Turning to our reversal of the ALJ's attorney fee award, claimant notes that the ALJ expressly found that the insurer "initiated a Request for Hearing which has not resulted in a disallowance or reduction of the Order on Reconsideration's compensation award." Based on such a finding, claimant challenges our conclusion that one of the three statutory requirements of ORS 656.382(2) were not met; *i.e.*, that "the ALJ did not find on the merits that the compensation award should not be disallowed or reduced."

We disagree with claimant's interpretation of our decision. To begin, in adopting the ALJ's "Findings of Fact," we expressly excepted the "last paragraph" of the ALJ's findings. Inasmuch as that paragraph contains the statement on which claimant now relies, it necessarily follows that we did not find that the ALJ's order constituted a decision that claimant's scheduled permanent disability award should not be disallowed or reduced. That conclusion is further confirmed by our express holding that "the ALJ's order was not a decision on the merits regarding the scheduled permanent disability award." On reconsideration of our decision, we adhere to our previously expressed reasoning and, as such, continue to hold that claimant is not entitled to a carrier-paid attorney fee under ORS 656.382(2).

Accordingly, we withdraw our October 21, 1998 order. On reconsideration, as supplemented herein, we republish our October 21, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In light of our reasons for denying claimant's motion, it is unnecessary for us to address claimant's assertion that we erred in inserting a "showing of prejudice" into the jurisdictional analysis regarding the insurer's failure to provide claimant's counsel with a copy of its request for review. Under such circumstances, we withdraw those portions of our previous decision which mentioned the lack of prejudice to claimant's counsel from not directly receiving a copy of the insurer's request.

In the Matter of the Compensation of
MARC GROSSETETE, Claimant
WCB Case No. 98-03265
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that awarded claimant an attorney fee of $5,000 for his attorney's services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the "Notice Facts."

CONCLUSIONS OF LAW AND OPINION

For claimant's attorney's services in prevailing over the employer's denial of claimant's right hand, wrist and forearm pain, the ALJ awarded an assessed attorney fee of $5,000. The ALJ determined that the fee amount was reasonable after applying the factors set forth in OAR 438-015-0010(4).[1] The ALJ stated that he particularly considered the time devoted to the issue and the value and nature of the results obtained for claimant. The ALJ also stated that, in considering the risk that claimant's counsel might go uncompensated, he took into consideration "the rate of risk by going to hearing according to the official records of the Director of DCBS."[2]

On review, the employer argues that the time devoted to the case was minimal and the benefit obtained was modest. The employer also contends that the ALJ erred in considering the risk factors for other cases rather than the present case. Finally, the employer objects to the ALJ's reliance on DCBS records that were not identified or disclosed.

Turning to the factors under OAR 438-015-0010(4), our review of the record reveals the following. Claimant's attorney successfully argued the claimant's "pain" condition was compensable. Following the April 20, 1998 denial, claimant filed the request for hearing on his own behalf. He did not retain an attorney until June 5, 1998. The hearing was held on July 22, 1998. At hearing, seventeen exhibits were admitted into evidence; however, claimant's counsel generated only two of the exhibits. The hearing lasted approximately one and one half hours. Claimant was the sole witness to testify on his behalf and claimant's counsel did not cross-examine the employer's only witness.

We conclude that, considering that claimant's counsel was retained approximately a month and a half prior to hearing and the hearing was a relatively brief one, the time spent on the case was less than that normally expended in compensability disputes presented to this forum for resolution. As compared to compensability disputes normally reviewed by this forum, the issue in this case was of average complexity and, given the nature of claimant's diagnoses and the conflict in medical opinions, claimant's attorney assumed a moderate risk that he might go uncompensated for his services.

Finally, the value of the case and the benefit secured for claimant consisted of medical services, as claimant did not lose time from work.

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[1] We note that the record contains neither a specific attorney fee request nor argument as to how the rule-based factors should be weighed in determining a reasonable fee. Therefore, the ALJ's explanation for the fee award sufficiently complied with the Supreme Court's instruction in *Schoch v. Leopold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), to set forth a "rational connection" between consideration of the factors and the fee awarded. *See Russell L. Martin*, 50 Van Natta 313 (1998).

[2] Subsequent to the ALJ's order, we held that the Director's "official records" did not represent agency decisions or orders and, as such, were not subject to administrative notice. *Carrie Newton*, 50 Van Natta 1750, 1753, n.1 (1998).

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of time, value, benefit, the nature of the proceedings, and risk, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing regarding the issue of compensability is $3,000. We therefore modify the ALJ's attorney fee award.

ORDER

The ALJ's order dated August 11, 1998 is modified. In lieu of the ALJ's attorney fee award of $5,000, claimant's counsel is awarded an attorney fee of $3,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
SHERYLEE P. LINDSAY, Claimant
Own Motion No. 98-0387M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Swanson, Thomas & Coon, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable facial lacerations, left shoulder contusion, cervical strain, thoracic strain, anxiety disorder and L2-4 decompression. Claimant's aggravation rights expired on August 13, 1998. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

We requested the parties' positions regarding the insurer's "work force" contentions. Claimant submitted various medical reports and a 1997 affidavit in support of her position that, although she was not working, she was willing to work, but it was futile for her to seek work due to her compensable conditions. The insurer submitted rebuttal documentation, contending that claimant's physicians released to her work following her surgery in 1996 and that she has not subsequently shown a willingness to work and/or seek work.

We take administrative notice of is claimant's pending hearing request regarding a June 18, 1997 Order on Reconsideration. (WCB Case No. 96-10797). As an issue arising from her request for hearing, claimant has raised permanent total disability. Determination of her entitlement to permanent total disability may well include consideration of claimant's "work force" status. *See* ORS 656.206; *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). Moreover, after considering the parties' submissions, there is apparently reliable evidence to support their respective "work force" positions regarding claimant's request for Own Motion relief. Under such circumstances, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

Consequently, this case is referred to the Presiding ALJ for assignment to an ALJ and the convening of a "consolidated" hearing regarding this case and WCB Case No. 96-10797. At the conclusion of the "consolidated" hearing, the assigned 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. 96-10797.[1] The assigned ALJ shall recommend to the Board whether it

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[1] We note that the record contains some indication that claimant may have filed a claim for a worsened condition before the expiration of her aggravation rights. If a claimant files a claim for a worsening of a compensable injury after the expiration of his/her aggravation rights, the claim is exclusively within the Board's own motion jurisdiction. *See* ORS 656.278; *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988); *John B. Shaw*, 50 Van Natta 685 (1998); *Robin S. Masse*, 42 Van Natta 1832 (1990). If, however, the claim for worsening is filed before the expiration of aggravation rights, the Board lacks own motion jurisdiction and the claim must, instead, be processed as an aggravation claim under ORS 656.273. Here, because the facts of this case present a question as to whether this matter is properly within the Board's own motion jurisdiction, we also request that the parties present evidence and the ALJ also make findings of fact and conclusions of law as to whether claimant perfected an aggravation claim before her aggravation rights expired. Based on those findings of fact, the ALJ shall also recommend to the Board whether it should order the claim reopened under our own motion jurisdiction.

should order the claim reopened under own motion jurisdiction for payment temporary disability compensation. Following of the ALJ's recommendation, the parties shall advise the Board of their respective positions. Thereafter, we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEO A. MONTGOMERY, Claimant
WCB Case No. 98-01951
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that: (1) found claimant was entitled to temporary disability from December 14, 1995 through April 3, 1997; and (2) awarded 10 percent (19.2 degrees) scheduled permanent disability for loss of use or function of claimant's right arm. On review, the issues are temporary disability and scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant compensably injured his right elbow on November 27, 1995. He returned to modified work, but, on April 3, 1996, was placed on a medical leave of absence due to "stress." (Ex. 40). That day claimant was given a drug test, which was positive for marijuana use. (Ex. 39). The employer suspended claimant on April 22, 1996 due to violation of its drug and alcohol policy. (Ex. 40-1).

Claimant signed a "Condition of Reinstatement or Continued Employment," also known as a "last chance agreement," on April 23, 1996. (Ex. 42). By terms of the agreement, claimant agreed to participate in a bona fide drug treatment program and to subject himself to random drug testing. According to the agreement, failure to take a test or a positive result would be cause for discharge.

On April 25, 1996, claimant tested positive for "cannabinoids." (Ex. 43). The employer advised claimant on May 17, 1996 that he was required to contact the counselor for a chemical dependency program by May 27, 1996 to schedule an evaluation. The employer emphasized that failure to make contact would result in discharge. (Ex. 48). The employer terminated claimant's employment on May 28, 1996 when claimant failed to contact his counselor as instructed. (Ex. 51).

On November 14, 1996, an Employment Division ALJ allowed claimant benefits, finding that the employer failed to correctly apply its drug testing policy. (Ex. 64-8).

A September 15, 1997 Determination Order closed the claim, awarding temporary disability from December 14, 1995 through April 3, 1997, but no permanent disability. (Ex. 80). The employer requested reconsideration, seeking termination of temporary disability on May 28, 1996, the date of claimant's discharge. (Ex. 83). Claimant cross-requested reconsideration, requesting a medical arbiter's examination to evaluate permanent disability. (Ex. 84).

After Dr. Bald performed a medical arbiter examination, which revealed reduced range of motion and a need for restrictions on repetitive use of claimant's right elbow, an Order on Reconsideration issued on February 26, 1998. It awarded 10 percent scheduled permanent disability for claimant's right elbow injury and affirmed the temporary disability award in the Determination Order. (Ex. 93). The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

We adopt and affirm the ALJ's reasoning and conclusions.

Temporary Disability

The ALJ rejected the employer's request for elimination of that portion of claimant's award of temporary disability after his May 28, 1996 discharge. In doing so, the ALJ concluded that claimant's discharge was related to the compensable injury. Moreover, the ALJ found that, even if claimant's employment was terminated for reasons other than the compensable injury, the employer did not comply with ORS 656.325(5)(b) because there was no evidence that the attending physician approved employment in a modified job that would have been offered to claimant had he remained employed.

On review, the employer again contends that claimant is not entitled to temporary disability after the date of his May 28, 1996 discharge. For the following reasons, we agree.

We first determine whether ORS 656.325(5)(b) applies to this case. That statute provides:

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

Here, claimant's employment was terminated for violation of work rules or other disciplinary reasons. At the time of termination, however, claimant was performing modified work and earning the same wage he earned at the time of injury. Thus, claimant was not entitled to receive temporary total disability benefits, because he was not sustaining wage loss as a result of the compensable injury. *See Cutright v. Weyerhaeuser Co.*, 299 Or 290, 295 (1985). Because claimant was not receiving (and was not entitled to receive) temporary total disability benefits at the time of termination, we hold that ORS 656.325(5)(b) does not apply in this case.[1] *George B. Orazio*, 49 Van Natta 1982 (1997).[2] Despite our finding that ORS 656.325(5)(b) does not apply to this case, we nonetheless find that claimant was not entitled to temporary disability benefits after he was discharged from employment.[3]

Temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. *Cutright*, 299 Or at 296; *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75 (1991). Where a worker leaves work for reasons other than an inability to work as a result of the compensable injury, the worker is not entitled to temporary disability benefits. *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 121 (1987); *Bruce Conklin*, 44 Van Natta 134 (1992); *compare Peggy J. Baker*, 49 Van Natta 40 (1997) (claimant terminated, at least in part, because of inability to perform regular work due to compensable injury).

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[1] We have other reasons for not applying ORS 656.325(5)(b). The statute requires a cessation of temporary total disability payments and commencement of temporary partial disability when a worker is discharged for disciplinary reasons or violation of work rules. In this case, the employer is challenging the substantive temporary disability award in a Determination Order. There was no cessation of temporary total disability payments in this case. Moreover, ORS 656.325(5)(b) also requires a transition from temporary total to temporary partial disability. Here, the Determination Order awarded "temporary disability." The Determination Order did not draw a distinction between temporary total and temporary partial disability. Inasmuch as the statute applies in cases of temporary total disability, and because the employer seeks the elimination of claimant's temporary disability award, not merely the reduction of temporary total to temporary partial disabiltiy, we are further persuaded that the statute is not applicable.

[2] Our decision in *Ricardo Chavez*, 50 Van Natta 90 (1998) does not require a different result. In *Chavez*, we applied ORS 656.325(5)(b) where the carrier "ceased" paying temporary disability even though the cessation of temporary disability payments did not correspond to the date of employment termination. In contrast to *Chavez*, there is no evidence that the employer paid temporary disability before or after claimant's employment was terminated.

[3] In *Orazio*, we determined that ORS 656.325(5)(b) did not apply in that case. Nevertheless, we found that the claimant was not entitled to temporary disability benefits after he was discharged from employment for disciplinary reasons. 49 Van Natta at 1982. In accordance with *Orazio*, we proceed with our analysis of whether claimant is entitled to temporary disability even though we have found that ORS 656.325(5)(b) is inapplicable.

Here, claimant left work on May 28, 1996, when he was discharged for disciplinary reasons.[4] The record does not establish that claimant left work due to an inability to work as a result of his compensable injury. Therefore, claimant is not entitled to temporary disability benefits after May 28, 1996. *See Michael D. Wingo*, 48 Van Natta 2477 (1996); *aff'd Wingo v. DPR Construction*, 153 Or App 237 (1998) (Judge Armstrong dissenting); *Patricia K. Stodola*, 48 Van Natta 613 (1996); *Terri Link*, 47 Van Natta 1711 (1995). Accordingly, we reduce claimant's award of temporary disability in the September 15, 1997 Determination Order.

Attorney Fees

The ALJ awarded claimant an attorney fee of $2,376 under ORS 656.382(2) for successfully defending against the employer's hearing request that sought reduction of claimant's temporary and permanent disability. On review, we have now reduced claimant's award of temporary disability. It follows that the employer was ultimately sucessful in partially reducing claimant's compensation. Therefore, we must reduce the ALJ's attorney fee award and award a fee that is limited to claimant's successful defense of the Order on Reconsideration's permanent disability award.

After considering the factors set forth 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 permanent disability issue is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

In addition, we have not reduced or disallowed claimant's award of permanent disability as a result of the employer's request for review. Therefore, we find that claimant's attorney is entitled to an assessed fee for services on review regarding the permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the permanent disability issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 17, 1998 is modified in part and affirmed in part. That portion of the ALJ's order that affirmed the award of temporary disability is modified. In lieu of the Determination Order's award of temporary disability, claimant is awarded temporary disability from December 14, 1995 through May 27, 1996. The ALJ's attorney fee award is also modified. In lieu of the ALJ's award, claimant is awarded an assessed fee of $1,500, payable by the employer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

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[4] We accept the employer's justification for claimant's discharge based on his failure to comply with the "last chance agreement". (Ex. 42). Although claimant argues, and the ALJ found, that the termination of claimant's employment was motivated by claimant's compensable injury, the propriety of the worker's termination is not within the purview of the workers' compensation laws. Rather, unlawful employment practices are governed by other laws, including the provisions of ORS Chapter 659. Moreover, based on our *de novo* review of the record, we are not persuaded that the employer terminated claimant's employment for a discriminatory purpose. Claimant was given ample opportunity to maintain his employment by complying with the last chance agreement that he signed. (Ex. 40, 44, 48, 49). He failed to comply, however. While an Employment Division ALJ determined that the employer failed to correctly apply its drug policy, we do not find that this necessarily proves that the termination was motivated by discriminatory animus related to claimant's compensable injury.

In the Matter of the Compensation of
RONNY G. HOLLAND, Claimant
WCB Case No. 98-02311
ORDER ON REVIEW
Malagon, Moore, 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) Johnson's order that affirmed an Order on Reconsideration award of 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of the right leg. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant has an accepted claim for fractures of the right tibia and fibula sustained in a September 30, 1996 injury. The treating physician, Dr. Thompson, performed a closing examination on September 24, 1997. (Ex. 8-3). The claim was closed by an October 21, 1997 Determination Order that awarded 4 percent scheduled permanent partial disability (PPD) for the right foot (ankle). (Ex. 10). Claimant requested reconsideration, and Dr. Neumann, orthopedic surgeon, conducted a medical arbiter examination on February 13, 1998. (Ex. 12).

Based on the arbiter's report, a February 26, 1998 Order on Reconsideration increased claimant's award to 25 percent scheduled PPD for the right leg. (Ex. 13). This award included impairment values for: restricted repetitive use of the right leg/knee (5 percent); restricted repetitive use of the right ankle/foot (5 percent); reduced range of right knee motion (5 percent); shortening of the right leg (5 percent); and reduced range of motion of the right ankle (9 percent). The insurer requested a hearing from the reconsideration order.

CONCLUSIONS OF LAW AND OPINION

At hearing, the ALJ rejected the insurer's contention that claimant was not entitled to a chronic condition award for his right leg/knee or his right ankle. In resolving this issue, we apply the "standards" set forth in WCD Admin. Order 96-072, which were in effect when the claim was closed on October 21, 1997. OAR 436-035-0003(2). Pursuant to these standards, claimant is entitled to a 5 percent scheduled chronic condition impairment value if a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is *significantly* limited in the repetitive use of his right lower leg (below knee/foot/ankle) or his right upper leg (knee and above). (Emphasis added). OAR 436-035-0010(5).

In determining impairment under the standards, we may rely on the findings of the attending physician at the time of closure, and the subsequent findings of the medical arbiter. ORS 656.245(2)(b)(B), 656.268(7)(a) and 656.268(7)(b); OAR 436-035-0007(12) and (13). Where the findings of the arbiter and the treating physician differ, we defer to the medical arbiter unless a preponderance of the evidence establishes a different level of impairment. OAR 436-035-0007(13).

In his closing examination report, Dr. Thompson noted mild impairment evidenced by a residual limp and shortening of the right leg. However, Dr. Thompson did not expressly or impliedly identify any restriction on claimant's ability to use his right knee/leg or ankle in a repetitive manner. Accordingly, any chronic condition award must be based on Dr. Neumann's arbiter report.

Dr. Neumann was instructed to "[n]ote whether or not this worker is significantly limited in the ability to repetitively use the right foot/ankle and/or leg or knee due to a diagnosed chronic and permanent medical condition arising out of the accepted condition(s)." Dr. Neumann gave the following response to this instruction:

> "This worker, in my opinion, has *some limitation* in the ability to repetitively use the right foot and ankle, as well as knee, due to a diagnosed chronic and permanent medical condition arising out of the accepted condition of fractures right distal tibia and right proximal fibula. *This is noted objectively by some loss of range of motion in his right ankle and knee.*" (Emphasis supplied)

Dr. Neumann further opined that claimant "is not prevented from walking or standing for more than two hours, cumulatively, in an eight hour period of time, due to the accepted condition." Finally, Dr. Neumann reported reduced motion of the right knee and ankle, one-half inch shortening of the right leg, and normal gait, along with the following additional findings:

> "[Claimant] is able to walk on his toes and heels, but it is somewhat awkward. He is able to do slow squat and rise. He can do a hop on either leg, but with some guarding. He can do a slow, stationary jog."

The ALJ reasoned that Dr. Neumann's opinion established a ratable loss of repetitive use of both the right leg/knee and the right ankle. On review, the insurer contends that the ALJ erred in deferring to the opinion of Dr. Neumann and, alternatively, that his arbiter's opinion does not establish a "significant" limitation within the meaning of OAR 436-035-0010(5). In support of the latter argument, the insurer relies on *Rena L. Rose*, 49 Van Natta 2007 (1997) (chronic condition not established by medical opinion that "claimant may have some difficulty in repetitive use of her hand").

We agree with the ALJ's deference to Dr. Neumann's arbiter report because it is based on a comprehensive and thorough evaluation of claimant's loss of use or function, which is the correct legal standard for rating scheduled PPD. OAR 436-035-0010(2). However, we do not agree that the arbiter's opinion establishes the requisite *significant* limitation of claimant's repetitive use of his right leg/knee and ankle.

In reaching this conclusion, we are aware that "magic words" are not required to establish impairment under the standards where the record as a whole satisfies claimant's burden of proof. *See Freightliner Corp v. Arnold*, 142 Or App 98 (1996); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). However, Dr. Neumann's use of the phrase "some limitation" in direct response to the Department's question asking for evidence of "significant limitation" indicates that the arbiter made a distinction between the two terms. Furthermore, the arbiter's conclusory comments do not explain how claimant's repetitive use is restricted. This lack of explanation is particularly problematic in light of claimant's successful return to his regular work activities without restriction. Finally, Dr. Neumann's findings do not indicate a significant restriction in claimant's ability to repetitively use his right knee/leg or ankle. Claimant's performance of certain activities in an awkward or slow manner does not establish that he could not sustain these activities on a repetitive basis; and claimant's reduced repetitive motion and shortened leg length is not a basis for a chronic condition award because claimant has received separate values for these impairments.

Consistent with the above reasoning, we conclude that claimant has not established entitlement to a chronic condition award for his right knee/leg or ankle. *Accord Rena L. Rose*, 49 Van Natta at 2007 (1997).[1] Consequently, claimant is entitled to an award of 17 percent scheduled PPD for the right leg, rather than the 25 percent scheduled PPD awarded by the ALJ.[2]

ORDER

The ALJ's order dated July 2, 1998 is reversed. In lieu of the ALJ's and the Order on Reconsideration award of 25 percent (37.5 degrees) scheduled permanent disability, claimant is awarded 17 percent (25.5 degrees) scheduled permanent disability for loss of use or function of the right leg. The ALJ's $1,800 assessed attorney fee award is reversed.

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[1] We reject claimant's argument that the *Rose* case is distinguishable because the medical expert in that case merely identified a "possible" chronic condition. The *Rose* Board also found the opinion unpersuasive because it did not identify the requisite "significant" restriction of repetitive use.

[2] The 9 percent value for reduced right ankle motion is converted to an 8 percent value for the right leg. OAR 436-035-0210(1). That value is combined with the 5 percent value for reduced right knee motion and the 5 percent value for a shortened right leg, for a total award of 17 percent scheduled PPD for the right leg. OAR 436-035-0007(17).

In the Matter of the Compensation of
LESLIE D. MARCUM, Claimant
Own Motion No. 98-0426M
OWN MOTION ORDER
Dennis W. Skarstad, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbar strain and left-sided L5-S1 disc herniation injury. Claimant's aggravation rights expired on March 13, 1991. SAIF recommends that we authorize the payment of temporary disability compensation.[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.*

We are persuaded that claimant's current condition (for which SAIF has accepted responsibility under the 1984 claim) constitutes a worsening of his 1984 compensable injury that requires surgery.[2] Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] SAIF notes that claimant has filed a "new injury" claim for his L5-S1 disc condition with a subsequent employer, who is also insured by SAIF. (Claim No. 7315140F). Reporting that claimant has requested a hearing from the "new injury" carrier's responsibility denial, SAIF requests that we suspend action on the own motion claim pending resolution of that litigation. (WCB Case No. 98-07656). Claimant objects to SAIF's request for suspension of action. Observing that he will either receive compensation under his "new injury" SAIF claim or under his 1984 SAIF claim, claimant asserts that SAIF can make an "internal adjustment" to reimburse itself for temporary disability awarded by an Own Motion Order under its 1984 claim, should SAIF ultimately be held responsible under his "new injury" claim. There would appear to be statutory support for this assertion. *See* ORS 656.268(15)(a).

It has been our policy, in own motion matters where there are available "administrative" remedies to postpone action until exhaustion of these administrative procedures. OAR 438-012-0050. Typically, when responsibility for a claimant's condition is the only issue which is contested, the matter is generally referred to the Department for a designation of a paying agent pursuant to ORS 656.307. Here, although responsibility is being contested under the "new injury" SAIF claim, SAIF has accepted responsibility in the 1984 own motion claim. Thus, the statutory requirements set forth in ORS 656.307 are not expressly applicable to claimant's 1984 own motion claim and claimant is unable to avail himself of the administrative remedies allowed under that statute and OAR 436-060-0180.

SAIF is not contesting the compensability and/or responsibility of claimant's current L5-S1 condition as it relates to the 1984 own motion claim. Additionally, SAIF acknowledges that surgery is appropriate for the compensable condition. In fact, SAIF recommends that we authorize reopening of claimant's own motion claim. There are no issues in the own motion claim for which claimant would need to avail himself of "administrative remedies." Under these particular circumstances, we decline to postpone action on the own motion claim pending resolution of claimant's litigation of a responsibility issue regarding his current condition under a "new injury" claim.

[2] This conclusion is based on the presumption that SAIF, under the 1984 claim, will ultimately be held responsible for claimant's condition. In the event that SAIF is ultimately found responsible for claimant's current condition under his "new injury" claim, SAIF may request reconsideration of this decision under OAR 438-012-0065(3) at that time.

In the Matter of the Compensation of
TERRI L. MORRIS, Claimant
Own Motion No. 97-0206M
OWN MOTION ORDER ON RECONSIDERATION
Reinisch, et al, Defense Attorneys

On September 15, 1998 we issued our Own Motion Order, in which we declined to reopen her claim for the payment of temporary disability compensation based on Administrative Law Judge (ALJ) Peterson's August 5, 1998 order which upheld the self-insured employer's April 28, 1997 compensability denial. Claimant submitted a letter wherein she states that she "disagree[s] with the denial of [her] claim and request[s] a hearing." Since our September 15, 1998 order was attached to claimant's correspondence, we interpret claimant's submission to be a request for reconsideration of that order.

On October 19, 1998 we abated our September 15, 1998 order to allow the employer sufficient time to respond to claimant's request. Having received the employer's response, we proceed with our review.

On April 28, 1997, the employer issued a compensability denial of claimant's current multi-level degenerative disk disease and central herniated disk at L4-5. Claimant requested a hearing contesting the employer's denial. (WCB Case No. 97-03834). By Opinion and Order dated August 5, 1998, ALJ Peterson upheld the employer's April 28, 1997 denial. That order was not appealed and has become final by operation of law.[1]

We may authorize the reopening of claim to provide temporary disability compensation when we find that there is a worsening of a *compensable* injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). Here, ALJ Peterson's order upheld the employer's denial. Thus, the current multi-level degenerative disk disease and central herniated disk at L4-5 remain in denied status. Consequently, we are not authorized to reopen claimant's claim because the record does not support a conclusion that claimant's *compensable* 1990 injury has worsened requiring surgery and/or inpatient hospitalization.[2] *See* ORS 656.278(1)(a).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 15, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] 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). 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). We have not received a request for review of ALJ Peterson's August 5, 1998 order. Furthermore, even if claimant's letter constituted a request for review of the ALJ's August 5, 1998 order, the request would be untimely because it was received by the Board on October 15, 1998 (more than 30 days after the ALJ's order). Therefore, the ALJ's order has become final by operation of law.

[2] As 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
GREGG MULDROW, Claimant
WCB Case No. 96-06766
ORDER ON REVIEW
Schneider, 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) Otto's order that set aside its denial of claimant's occupational disease claim for left shoulder impingement syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In July 1993, while working as a painter for an auto body shop, claimant developed right shoulder pain after color sanding the hood of a car. He sought treatment from Dr. Johansen, who diagnosed bursitis. (Ex. A-4). Dr. Johansen then referred claimant to Dr. Hanley, who diagnosed right shoulder rotator cuff impingement. (Ex. A-7). Dr. Hanley treated claimant's right shoulder with a subacromial injection, which immediately reduced claimant's symptoms. By early September 1993, Dr. Hanley reported that claimant's right shoulder problem had essentially resolved. (Ex. A-9). Claimant continued to work as an auto body painter until June 1995. (Tr. 31).

In October 1995, claimant began working for another employer, a manufacturer of computerized cut-off saws. (Tr. 23). He was hired as a painter and, for the most part, his job entailed painting and lifting the machine parts in and out of the paint booth. At times, claimant also helped with other tasks, including working in the machine shop, electrical department or welding area. Claimant occasionally lifted heavy objects, sometimes with the assistance of lifting devices or other employees. This job was more physical than claimant's prior employment painting cars. (Tr. 32-33, 40-45, 53-57).

In January 1996, claimant saw Dr. Johansen for a physical. Dr. Johansen noted that claimant reported occasional paresthesia in his left arm and shoulder, especially when he lay on his right side. Dr. Johansen also noted that claimant had gained 25 pounds over the past two years, mostly muscle mass. (Ex 2).

On March 14, 1996, claimant returned to Dr. Johansen complaining of left shoulder pain. Dr. Johansen diagnosed probable impingement syndrome and again referred claimant to Dr. Hanley. (Ex. 2-3).

On March 18, 1996, claimant saw Dr. Hanley, who found a significant subacromial spur and recommended conservative treatment. Dr. Hanley opined that the spur developed over the course of years and not just within the last five months. (Ex. 3). In June 1996, Dr. Hanley recommended surgery to remove the subacromial spur and rotator cuff calcification. (Ex. 9).

Claimant made a claim for his left shoulder impingement syndrome against the computerized saw manufacturer, which the insurer denied. Claimant requested a hearing.[1]

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Johansen, the ALJ determined that claimant had shown that his work activities were the major contributing cause of his left shoulder impingement syndrome. On review, the insurer contends that Dr. Johansen's opinion is unpersuasive and claimant has not established the compensability of his left shoulder impingement syndrome by a preponderance of the evidence. We agree.

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[1] Initially, the insurer denied only responsibility for claimant's condition. At the original hearing, ALJ Neal allowed the insurer to amend its denial to include compensability, but denied claimant's request for a continuance to respond to the newly raised issue. ALJ Neal then upheld the insurer's compensability denial and claimant appealed. On review, the Board held that, although a carrier may amend its denial at hearing, ALJ Neal erred in denying claimant's request for a continuance. The Board therefore vacated the Opinion and Order and remanded the case to the Hearings Division for further development of the record on the compensability issue. *See Gregg Muldrow*, 49 Van Natta 1866, 1867 (1997). On remand, the matter was heard by ALJ Otto.

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

Claimant's internist, Dr. Johansen, opined that claimant's increased muscle bulk combined with his increased shoulder use during the course of employment to become the major cause of his left shoulder impingement syndrome or, to the extent that claimant had past problems with his left shoulder, to worsen his previous condition to the point that surgical intervention was indicated. Dr. Johansen reported that claimant's work activity for the computerized saw manufacturer could be considered the major cause because it contributed to his additional muscle bulk as well as required the increased use of his left shoulder. (Ex. 11).

On the other hand, Dr. Hanley, an expert in diseases and treatment of the shoulder who treated claimant on referral from Dr. Johansen, indicated that he could not, within a reasonable probability, identify claimant's work activity as the major cause. (Ex. 12, pp. 38-39). Unlike Dr. Johansen, Dr. Hanley doubted that claimant increased his muscle mass as a result of his work activity. *Id.* at pp. 21-31. Dr. Hanley explained that although claimant may have been lifting and manipulating steel parts in connection with his job, it would not cause someone of claimant's age (40) to "bulk up" an additional 25 pounds. Dr. Hanley noted that claimant's work activity may have improved his muscle tone, but it would not cause him to add muscle mass. *Id.* at pp. 23-25

With regard to claimant's left shoulder, Dr. Hanley explained that claimant had spurring which preexisted his employment and contributed to the development of his impingement syndrome. *Id.* at p. 38. Dr. Hanley also noted that, because claimant had a history of right shoulder impingement, claimant may also have a congenital, anatomic predisposition to shoulder problems, although he could not be certain in the absence of further treatment and/or surgery. *Id.* at pp. 35-38. Due to the number of factors contributing to claimant's condition, however, Dr. Hanley ultimately declined to name claimant's work activity as the major cause. *Id* at p. 40.

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. *Weiland v. SAIF*, 64 Or App 810 (1983). But where the case involves expert analysis rather than expert external observation, the status of the treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284, 287 (1986).

In this case, both doctors have treated claimant, and have had the opportunity to observe him over time. Although Dr. Johansen's opinion supports the compensability of claimant's left shoulder impingement, Dr. Hanley's does not. For the reasons set forth below, we find Dr. Johansen's opinion insufficient to sustain claimant's burden of proof.

First, we question the accuracy of the history on which Dr. Johansen's opinion is based. For example, in identifying claimant's work activity for the computerized saw manufacturer as the major cause of claimant's left shoulder impingement, Dr. Johansen assumed that much of claimant's 25 pound weight gain and additional muscle bulk was attributable to this work activity. But, in January 1996, when Dr. Johansen first noted that claimant had gained 25 pounds in two years, claimant had only been working for this employer for four months. Even claimant could not recall how much he weighed at the time he was hired, and to what extent he gained weight and muscle mass after his October 1995 hire date, as opposed to during the prior 20 months (when he was mostly working an auto body painter).[2] (Tr. 22-23).

Dr. Johansen also understood that claimant's new job entailed frequent lifting and carrying of heavy steel materials and products. The record, on the other hand, establishes that although claimant's job for this employer was more physical than his prior employment, it required only occasional lifting of heavy steel parts without assistance. The majority of claimant's work activities between October 1995

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[2] Claimant's one-time supervisor, Todd Ullrich, testified that claimant was "extremely buff" and "very muscular" when he was hired by the employer in October 1995. (Tr. 41). Mr. Ullrich also testified that did not notice any weight gain in claimant from October 1995 through March or April 1996. *Id.*

and March 1996 involved painting and moving machine parts of varying weights and sizes (ranging from 2 to 5 lbs. to 50 lbs.) (Tr. 52-59). Because of these inconsistencies, we find Dr. Johansen's opinion unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Second, unlike Dr. Hanley's assessment, Dr. Johansen's opinion does not address the extent to which claimant's preexisting spurring contributed to the development of his impingement syndrome. Dr. Johansen also does not expressly consider claimant's prior history of right shoulder impingement as evidence that claimant may have had an anatomic predisposition to shoulder problems. Because Dr. Johansen's opinion does not evaluate the relative contribution of these other causal factors and explain why the work exposure contributes more to claimant's condition than all other causes or exposures combined, it does not satisfy the major contributing cause standard. *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).

Third, Dr. Johansen is a general practitioner and, unlike Dr. Hanley, is not a specialist in the cause and treatment of shoulder conditions. Indeed, Dr. Johansen referred claimant to Dr. Hanley for further evaluation and treatment of his shoulder complaints. (Exs. A-5, 2-3). Because Dr. Johansen has no specific expertise in this area, we do not find his opinion more persuasive than that of Dr. Hanley. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980) (where the medical opinions are divided, we generally rely on physicians who are specialists in the field of question).

For these reasons, we find that claimant has failed to establish the compensability of his left shoulder impingement syndrome. We therefore reinstate the insurer's denial.

ORDER

The ALJ's order dated July 21, 1998 is reversed. The insurer's amended compensability denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

November 25, 1998 Cite as 50 Van Natta 2246 (1998)

In the Matter of the Compensation of
DARRELL J. MOULTON, Deceased, Claimant
WCB Case No. 98-00554
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant[1] requests review of Administrative Law Judge (ALJ) Herman's order that set aside the insurer's denial of a fatal injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 1, 1998 is affirmed.

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[1] Claimant is deceased and represented in these proceedings by his beneficiary. However, for ease of reference, we shall use the word "claimant" rather than "claimant's beneficiary" in our order.

In the Matter of the Compensation of
DONALD L. POTTORFF, Claimant
WCB Case No. C8-02005
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bruce D. Smith, Claimant Attorney
Hoffman, et al, Defense Attorneys

Reviewed by Board Members Biehl 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 disapprove the proposed disposition.

The proposed CDA provided that the claim had not been closed, but that the parties stipulated that claimant was permanently and totally disabled. Further, the agreement provided that claimant's spouse was a party to the CDA "since rights to survivor's benefits due to claimant's permanent total disability status are being released."

On September 15, 1998, we wrote the parties requesting an addendum to the CDA for the following reasons. First, because the parties' CDA could be interpreted as awarding PTD benefits, we requested clarification.[1] Second, we requested that the parties remove claimant's spouse from the CDA. In making this latter request, we noted that a claimant's spouse does not become a beneficiary until a claimant dies during the period of permanent total disability. *See Ralph L. Witt*, 46 Van Natta 1902 (1994); *see also Robert K. Wilson*, 45 Van Natta 1747 (1993) (CDA assigning portion of proceeds to spouse prior to the claimant's receipt is unreasonable as a matter of law). Because claimant is not permanently and totally disabled and is still living, we reasoned that his spouse may not release benefits to which she is not entitled through claimant's CDA.

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. On November 5, 1998, we sent a second addendum request to the parties' attorneys. To date, the parties have not submitted the addendum as requested.[2] Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any benefits that were stayed by submission of the proposed disposition. *See* OAR 436-060-0150(4)(i) and (6)(e).

Should the parties disagree with our interpretation of the CDA, 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.

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[1] In requesting this clarification, we noted that it is impermissible for a CDA to accomplish claim processing functions since it is not one of the objectives to be resolved with such an agreement. *Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992). We also noted that we would decline to approve a CDA that awarded PTD benefits, since CDAs are not designed for purposes of claim processing. *See Kenneth D. Chalk*, 48 Van Natta 1874, n 1 (1996).

[2] We acknowledge receipt of letters from claimant's and the insurer's attorneys requesting withdrawal of the CDA. 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) (Board may disapprove a CDA if the worker, the insurer or self-insured employer requests disapproval within 30 days of submitting the CDA for approval).

In the Matter of the Compensation of
ANN L. BRITT, Claimant
WCB Case Nos. 97-02751, 97-02750 & 96-10231
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

EBI Companies (EBI) requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of compensability and responsibility for claimant's "new injury" claim for her current right knee condition; and (2) upheld Liberty Northwest Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We begin by briefly recounting the relevant facts. Claimant injured her right knee in February 1991, as a result of which Liberty Northwest accepted a nondisabling right knee strain. An April 17, 1991 MRI scan showed mild degenerative changes in all three compartments of the right knee, with no meniscal tear. (Ex. 8). Claimant's past weight gain (to 280 pounds in 1982-83, 179 pounds in 1991) was felt to be a contributing factor in her articular cartilage wear. (Ex. 7).

X-rays taken in October 1994, when claimant sought treatment from Dr. James for anterior knee pain, revealed severe post-traumatic degenerative arthritis of the patellofemoral joint of the right knee with moderately severe patellofemoral malalignment on both knees. (Ex. 10-2). On June 19, 1995, x-rays showed progressive narrowing of the medial compartment. Dr. James diagnosed a medial meniscus tear of the knee, which he attributed to the 1991 injury. (Ex. 10-3). He opined, however, that the major contributing cause of claimant's then-current condition was her preexisting arthritic condition. (Ex. 11-2). Liberty Northwest denied claimant's current condition. The denial was not appealed.

In July 1996, claimant returned to Dr. James, seeking treatment for increased pain in her right knee after injuring it at work in April 1996. Dr. James noted moderate atrophy in claimant's right thigh, and x-rays revealed little change in her right knee since 1995. James noted that claimant's patellofemoral arthritis had been clinically insignificant. He diagnosed a significant tear of the lateral and medial meniscii of the right knee and recommended arthroscopic debridement surgery. (Ex. 15). The surgery was performed on August 13, 1996; Dr. James found a significant medial meniscus tear.

Claimant filed a "new injury" claim with EBI and an aggravation claim with Liberty Northwest. Each carrier denied compensability and responsibility.

The ALJ concluded that claimant proved compensability of her "new injury" claim against EBI. On review, EBI contends that the portion of its denial that specifically denied claimant's preexisting degenerative arthritis condition should be upheld, as claimant was not making a claim for any condition other than her medial meniscus tear. EBI also contends that the preexisting degenerative condition, not claimant's injury, is the major contributing cause of her current condition. We disagree with each of EBI's contentions.

As the ALJ noted, claimant conceded at hearing that her current right knee condition is a "combined condition," consisting of her right knee injury and her preexisting degenerative arthritis and meniscal tears. Moreover, Dr. James indicated that the preexisting meniscus tears were "part and parcel" of claimant's ongoing degenerative process. (Ex. 43-16). Because the condition at issue preexisted the compensable injury and "combined" with the compensable injury, they are compensable

as part of a "combined" condition pursuant to ORS 656.005(7)(a)(B),[1] if the compensable injury is the major contributing cause of the disability or medical treatment of the combined condition. *See SAIF v. Nehl*, 148 Or App 101, *recon* 104 Or App 309 (1997), *rev den* 326 Or 389 (1998); *Gregory C. Noble*, 49 Van Natta 764, 767 (1997), *aff'd mem Liberty Northwest Ins. Corp. v. Noble*, 153 Or 125 (1998).

Based on our review of the medical evidence from Dr. Vesseley and Dr. James, we agree with the ALJ that the compensable injury is the major contributing cause of the disability and medical treatment for claimant's combined condition. Accordingly, we conclude that claimant's preexisting degenerative arthritic condition, including the meniscus tears, is compensable as part of the "combined" condition, which consists of the compensable injury and the preexisting right knee conditions. Our inquiry, however, does not end here.

In *Karen S. Carman*, 49 Van Natta 637 (1997) and *Mitchell D. Joy*, 50 Van Natta 824 (1998), we concluded that the denial of the independent compensability of a preexisting condition could coexist with an accepted "combined" condition, provided that the compensable injury did not worsen or accelerate the preexisting condition.

In this case, based on Dr. James' opinion, we find that the compensable 1996 injury worsened the preexisting arthritic condition by damaging the meniscus, the arthritic joint, and the arthritic area under the kneecap. (Ex. 43-14, -17). Claimant, however, did not seek to establish the independent compensability of the preexisting degenerative arthritis. (Tr. 2). Therefore, our holding setting aside the denial in its entirety should not be construed as a finding that the preexisting degenerative arthritis in claimant's right knee is independently compensable, in and of itself.

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 the compensability issue, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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.

ORDER

The ALJ's order dated April 17, 1998 is affirmed. For services on review, claimant's counsel is awarded a fee of $1,500, to be paid by EBI Companies.

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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."

November 25, 1998 Cite as 50 Van Natta 2249 (1998)

In the Matter of the Compensation of
JOHN R. SPOERER, Claimant
WCB Case No. 98-02698
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

The last full sentence on page four is modified to read: "I also find that the claimant's work activities at Emery & Sons Construction *combined with his preexisting degenerative condition* to result in disability and require treatment, including surgery."

In addition, we do not find Dr. Gooch's opinion unpersuasive because it is internally inconsistent. Opinion and Order p. 4, n. 1. *See Robinson v. SAIF*, 147 Or App 157, 160 (1997) (Certainty not required to establish medical causation). Nonetheless, we agree with the ALJ that Dr. Gooch's opinion is inadequate to carry claimant's burden of proof, because we find no indication that Dr. Gooch compared the relative contributions of claimant's severe preexisting degeneration and his work activities.

ORDER

The ALJ's order dated July 20, 1998 is affirmed.

In the Matter of the Compensation of
KATHERINE V. DUTTON, Claimant
WCB Case No. 98-03475
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied her request to continue the hearing to allow her to attempt to enforce a subpoena; (2) found that her claim was not prematurely closed; and (3) declined to award penalties for allegedly unreasonable claim processing. In her brief, claimant argues that the ALJ relied on evidence not admitted at hearing. On review, the issues are continuance (remand), evidence, premature closure, and penalties. We affirm.

FINDINGS OF FACT

The insurer accepted claimant's injury claim for a November 22, 1996 disabling lumbosacral strain. A December 1, 1997 Determination Order closed the claim. Claimant requested reconsideration, contending that the claim was prematurely closed.

An April 24, 1998 Order on Reconsideration affirmed the Determination Order. Claimant requested a hearing.

At hearing, claimant requested a continuance on two grounds. First, she argued that she was surprised by the insurer's failure to submit a certified copy of the Director's reconsideration record and asked the ALJ to continue the hearing to allow her to obtain that record. The ALJ found that *claimant's* failure to timely submit evidence did not amount to extraordinary circumstances justifying a continuance and denied her request for a continuance on this basis.

Second, claimant requested a continuance to allow her to attempt to enforce a subpoena to require a witness to attend the hearing. The ALJ denied claimant's request, finding that claimant had served the subpoena improperly.

Finally, the ALJ held that the claim was not prematurely closed and that claimant was not entitled to penalties or attorney fees. Claimant requested review.

CONCLUSIONS OF LAW AND OPINION

Claimant states that the issues on review are: (1) whether the ALJ erred in failing to rely on the attending physician's opinion or a preponderance of the evidence in determining that claimant's injury claim was not prematurely closed; and (2) penalties and attorney fees "for premature closure." (Claimant's appellant's brief, p. 1).

Preliminary Matters

Claimant requested a continuance to allow her to attempt to enforce a subpoena.[1] On review, claimant explains that she sought to compel the insurer's claim processor to attend the hearing to answer questions about his knowledge of the identity of claimant's treating physician. She expressly acknowledged that the subpoena was relevant solely in the context of her claim for penalties for allegedly unreasonable claim processing. (*See* Tr. 8-9; Claimant's appellant's brief, p. 4).

The ALJ denied claimant's motion for a continuance on this basis, reasoning that the subpoena had not been properly served under ORCP 55. We express no opinion about the propriety of the ALJ's ruling, because a penalty would not be warranted even if the intended witness' evidence had been presented.[2] Under these circumstances, we find no compelling reason to remand for further development of the record regarding the subpoena.

We also acknowledge the evidentiary dispute and claimant's motion at hearing for a continuance to obtain a copy of the Director's record on reconsideration. The insurer submitted a packet of documentary exhibits to the ALJ before hearing. But when the hearing convened, the insurer refused to stipulate that the exhibits it had submitted were contained in the Director's reconsideration record. Claimant contended that she had no warning that the submitted exhibits would be treated as anything other than certified by the Department. The ALJ essentially refused to hear claimant's evidentiary arguments and denied her motion to continue the hearing on this basis. (*See* Tr. 20). Instead, the ALJ admitted some documents and excluded others.

On review, the insurer relies on "Exhibits 17 and 25" and claimant objects because they were not admitted. Claimant also argues that the ALJ's opinion on the merits is not supported by law or evidence, contending that there is no attending physician's opinion finding claimant medically stationary and no preponderance of medical evidence to that effect. We treat claimant's contentions as a motion to remand for development of the record and we consider the sufficiency of the record on *de novo* review.

Claimant is correct that the ALJ failed to admit two documents referenced in the Order on Reconsideration--proposed Exhibits 17 and 25 (an insurer-arranged examiner's report and Dr. Chaffee's concurrence with that report). The Appellate Unit relied on these documents in its Order on Reconsideration (in determining that claimant was medically stationary on the date of closure). (*See* Ex. 39). They were admissible.[3] Nonetheless, we need not determine the extent of the ALJ's evidentiary errors[4] or remand for further development of the record, because we find that the result would be the same, even if all the proposed evidence submitted is considered.[5]

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[1] The subpoena, proposed exhibit 44, was not admitted at hearing, but it is in the hearings file.

[2] Claimant argues that the insurer obstructed her identification of Dr. Gerry as her new attending physician because its claims processor did not submit to cross-examination about the insurer's knowledge of Dr. Gerry's status. However, as we explain herein, even if Dr. Gerry was claimant's attending physician at claim closure, Dr. Gerry's opinion does not carry claimant's burden of establishing that there was a reasonable expectation of material improvement in claimant's condition as of claim closure. Therefore, Dr. Gerry's arguable status as attending physician would not alter our conclusions that claim closure was proper and there is no penalty basis.

[3] We are particularly mindful that neither party *objected* to any of the exhibits offered at hearing.

[4] OAR 438-007-0018(7) provides:

"At the hearing, rather than presenting the Director's reconsideration record for admission, the parties shall present their oral or written stipulation identifying the exhibits in the hearing record which were also included in the Director's reconsideration record under ORS 656.283(7). If the parties cannot reach an agreement, any disputed portions of the Director's reconsideration record may be presented for admission."

The rule contemplates that the parties will agree at hearing that submitted exhibits were included in the reconsideration record. The rule also implicitly provides that, absent the parties' agreement, the ALJ should determine whether each of the submitted exhibits were included in the reconsideration record. *See Bruce A. Waggoner*, 50 Van Natta 2175 (1998).

[5] In other words, we have considered all the proposed evidence, including claimant's "post hearing" submissions, to determine whether remand is appropriate.

Premature Closure

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.[6]

Claimant relies on Dr. Gerry's December 16, 1997 report referring claimant to a pain center as evidence of anticipated improvement in his condition, in support of her contention that the claim was prematurely closed. (*See* Ex. 32; *see also* Ex. 30). But Dr. Gerry's December 16, 1997 referral does not suggest that improvement was reasonably anticipated *as of the December 1, 1997 claim closure. See Joyce A. Staudenraus*, 49 Van Natta 2162 (1997) (The dispositive question in resolving a premature closure issue is: Was there a reasonable expectation of material improvement in the compensable condition *as of claim closure*?). Moreover, even if the December 16 referral related to claimant's December 1 condition, we would agree with the ALJ that a referral to determine whether further treatment would help claimant does not amount to a reasonable expectation of improvement. Accordingly, we agree with the ALJ that claimant has not carried her burden of proving that her claim was prematurely closed.[7]

Finally, because the claim was not prematurely closed, there is no basis for penalties or attorney fees (*i.e,* no amounts "then due" and no compensation to resist paying).

ORDER

The ALJ's order dated August 3, 1998 is affirmed.

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[6] We specifically agree with the ALJ that the attending physician's opinion is not required to determine medically stationary status. *William M. Heck*, 48 Van Natta 1071, 1071-72 (1996).

[7] In reaching this conclusion, we have considered all the exhibits submitted to determine whether the record was adequately developed on the premature closure issue. Finding nothing in the exhibits submitted (but not admitted) that would likely affect the outcome, we also find no compelling reason to remand for further development of the record.

In the Matter of the Compensation of
MICHAEL R. VLCEK, Claimant
WCB Case No. 97-07849
ORDER ON REVIEW
Daniel J. Denorch, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that the SAIF Corporation's partial denial of claimant's current right knee condition was not precluded by a prior Stipulation; and (2) upheld the denial. On review, the issues are the effect of the Stipulation and compensability.

We adopt and affirm the ALJ's order. *See Amber D. Applebee*, 45 Van Natta 2270, 2272 (1993), *aff'd mem* 129 Or App 304 (1994) (Where the terms of the Stipulation determined only that SAIF would rescind its denial and reopen the claim, the agreement was not an acceptance of the claimant's condition).

ORDER

The ALJ's order dated May 29, 1998 is affirmed.

In the Matter of the Compensation of
ADAM P. FOSS, Claimant
WCB Case No. 98-02693
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that awarded 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back injury. On review, the issue is unscheduled permanent disability.

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

The ALJ awarded 8 percent unscheduled permanent disability based on the range of motion findings contained in the medical arbiter's (Dr. Becker's) report.[1] (Ex. 72). On review, the insurer contends that claimant has not sustained his burden of proving that he has injury-related permanent impairment. The insurer notes that claimant's attending physician, Dr. Klass, concurred with the report of examining physicians (Drs. Watson and Coletti), who opined that claimant did not have permanent impairment due to his compensable lumbar strain. For the following reasons, we find that the ALJ properly relied on the medical arbiter's report.

ORS 656.283(7) and 656.295(5) provide that the evaluation of the worker's disability shall be as of the date of issuance of the reconsideration order. Because the January 26, 1998 arbiter's examination was conducted closer in time to the March 20, 1998 reconsideration order than the September 17, 1997 examination by Drs. Watson and Coletti, and because the arbiter's report is a thorough and well-reasoned evaluation of claimant's injury-related impairment, we rely on the medical arbiter's findings. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

If a medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. SAIF v. Danboise, 147 Or App 550, 552-53, *rev den* 325 Or 438 (1997). Where a medical arbiter relates the claimant's impairment to causes other than the compensable injury, however, the medical arbiter's opinion is not persuasive evidence of injury-related impairment. *Julie A. Widby*, 46 Van Natta 1065 (1994).

In this case, the medical arbiter, Dr. Becker, was specifically asked to perform an examination of claimant's low back and describe any objective findings of permanent impairment "resulting from the accepted condition(s)." (Ex. 68-2, emphasis in original). The medical arbiter found that claimant had lost range of motion in the lumbar spine. (Ex. 72-3). Dr. Becker did not attribute the reduced range of motion to causes other than the compensable injury and observed that there were no inconsistencies in the examination. (Ex. 72-3). In fact, Dr. Becker specifically reported that his findings were valid. (Ex. 72-5). Under these circumstances, we conclude that the arbiter's impairment ratings for lost range of motion relate to the work injury.

Accordingly, we find that the ALJ correctly awarded claimant 8 percent unscheduled permanent disability. We, therefore, affirm.

Because we have not reduced or disallowed claimant's compensation, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the permanent disability issue is $1,000, 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.

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[1] Claimant did not argue at hearing or on review that he was entitled to values for age, education and adaptability.

ORDER

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

Board Member Moller dissenting.

I disagree with the majority's conclusion that claimant satisfied his burden of proving that he sustained injury-related permanent impairment. Because I do not believe that claimant has established the presence of permanent impairment, I must dissent.

Dr. Becker, the medical arbiter, provided findings regarding reduced range of motion. Dr. Becker's report also indicates, however, that claimant has degenerative disc disease and that claimant's July 7, 1997 injury caused chondromalacia symptoms. (Ex. 72-5). When asked whether claimant was permanently precluded from performing activities, Dr. Becker specifically noted that claimant could expect improvement in his condition with the passage of time and resolution of his facet chondromalacia. (Ex. 72-6).

In light of these comments, I am not persuaded that claimant's range of motion limitations are necessarily permanent. Combine this with the attending physician's concurrence with the report of the examining physicians, Drs. Watson and Coletti, who opined that claimant does not have permanent impairment due to his compensable injury, and I would conclude that claimant does not have permanent impairment. Because the majority concludes otherwise, I must part company with its decision to affirm the ALJ's order.

In the Matter of the Compensation of
RANDALL S. GRANGER, Claimant
Own Motion No. 98-0385M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable right knee sprain. Claimant's aggravation rights on that claim expired on January 6, 1998. 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 arthroscopic surgery. Thus, we conclude that claimant's compensable injury worsened requiring surgery.[1]

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).

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[1] Dr. Galt, claimant's attenting physician, reported that claimant was considering the surgical options that were posed to him during a June 1998 examination. Claimant has subsequently indicated that Dr. Galt has scheduled claimant's knee surgery for approximately December 16, 1998. In light of such circumstances, we are persuaded that claimant's compensable condition has worsened requiring surgery.

Here, SAIF contended that claimant was not in the work force at the time of his current disability because he listed himself as "disabled as employer status when he went to Ashland Community Hospital for his MRI." Additionally, SAIF contended that claimant's failure to provide proof of earnings further demonstrated that he was not in the work force.

In response to SAIF's contention, claimant has submitted his 1997 tax return, 1997 W-2 form, 1997 and 1998 1040-ES tax payment vouchers and paystubs which span a time period between June 1, 1997 through October 3, 1998. 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.

November 27, 1998 Cite as 50 Van Natta 2255 (1998)

In the Matter of the Compensation of
ANITA D. JIMENEZ, Claimant
WCB Case Nos. 98-00261 & 98-00260
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's occupational disease claim for a right ulnar neuropathy condition; and (2) awarded a $4,000 assessed attorney fee. On review, the issues are compensability and attorney fees.

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

The last sentence on page 3 is modified to read: "Since claimant had symptoms, but no *electrodiagnostic (objective)* findings of neuropathy on the left, we do not deem Dr. James' failure to discuss the etiology of the left sided symptoms to be a weakness in his explanation of the right sided condition."

We acknowledge that Dr. James changed his opinion over time. (*See* Exs. 58, 62, 68, 69; *see also* Exs. 61, 67). However, we find his ultimate reasoning supporting the claim persuasive because it is based on additional information about claimant's work and off-work activities (and previous variations were based on insufficient relevant information).

Finally, we evaluate claimant's attorney fee for services at hearings as follows.

The ALJ awarded a $4,000 attorney fee, explaining that he relied more heavily on claimant's counsel's demonstrated expertise than on the number of hours devoted to the case at the hearings level. The employer argues that the ALJ erred because claimant's counsel submitted a statement of services for 11.4 hours of time spent on the case and his normal hourly rate is $160 per hour. Therefore, the employer contends, claimant only "requested" a $1,824 fee. We disagree.

On *de novo* review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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 note that "time devoted to the case" is but one of the factors for consideration under the rule.

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

Approximately 74 exhibits were received into evidence, with at least one generated and submitted by claimant's counsel. The record also includes a "post-hearing" deposition of 25 pages. The hearing transcript consists of approximately 38 pages. Three witnesses, including claimant, testified. Medical causation is complicated in that claimant has had multiple upper extremity problems, including bilateral wrist and forearm tendinitis and carpal tunnel syndrome, as well as right ulnar neuropathy. The claim's value and the benefits secured are significant, because substantial medical services are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the medical complexity of the case.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments and claimant's counsel's statement of services, we conclude that $4,000 is a reasonable attorney fee for services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and evaluating claimant's counsel's submission in light of the employer's objection)[1], the medical complexity of the case, 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 $1,000, 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 July 9, 1998 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

[1] We do not find that claimant "requested" a fee for 11.4 hours of work calculated at a rate of $160 per hour. Instead, we note that claimant's counsel asked the ALJ to take his statement of services "into consideration," in determining a fee.

In the Matter of the Compensation of
DONNA A. GOODMAN-HERRON, Claimant
WCB Case No. 94-09926
ORDER OF ABATEMENT
Daniel Snyder, Claimant Attorney
David L. Runner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 30, 1998 Order on Remand that set aside its denial of claimant's claim for a psychological disorder. Specifically, SAIF challenges our determination that claimant was sexually assaulted by her coworker. Contending that claimant's testimony concerning the incident was implausible, SAIF asks that we reexamine our decision to accept the Administrative Law Judge's credibility finding, or further explain the basis for our ruling.

In order to consider claimant's motion, we withdraw our October 30, 1998 order. Claimant is granted the opportunity to respond. To be considered, that response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRANDI L. NEWMAN, Claimant
WCB Case No. 98-01837
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's head injury claim. On review, the issue is whether the injury is in the course and scope of employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the last paragraph. We also correct the date in the first paragraph to "October 27, 1997."

CONCLUSIONS OF LAW AND OPINION

Claimant, a gas station attendant, fell at work and suffered a closed head injury. Claimant contends that the injury is in the course, and arose out of, employment because she slipped in some diesel fuel. The ALJ agreed with SAIF that claimant fell after a syncopal (fainting) episode and, thus, failed to prove compensability. On review, claimant challenges this conclusion, asserting that the more persuasive evidence shows that claimant slipped and fell.

We first note claimant's assertion that the ALJ erred in sustaining SAIF's objection to testimony from William O'Brien, a paramedic who arrived at the scene in response to an "emergency" call and initially treated claimant. Based on OAR 438-007-0016,[1] the ALJ refused to admit Mr. O'Brien's testimony that claimant's manner of falling demonstrated that she slipped and fell.

We conclude that, whether or not we consider Mr. O'Brien's testimony, claimant did not carry her burden of proof. As explained by the ALJ, there was testimony by two eye witnesses to the event. A customer, Jeffrey Bass, testified that he saw claimant pinwheeling her arms before she fell, thus showing that she was conscious before hitting her head. (Tr. 47, 50). A former coworker, William Dugger, stated that he saw claimant by one of the pumps and noticed her head slump down before she fell over, thus showing that she lost consciousness before hitting her head. (*Id.* at 145, 147).

We find both witnesses equally persuasive. That is, based on the substance of their testimony, both witnesses were credible; neither witness showed inconsistencies from previous statements nor a bias for one party. Consequently, we find the evidence in equipoise concerning whether claimant slipped before falling or fainted before falling. Because the evidence concerning this central fact is in equipoise, we conclude that claimant did not carry her burden of proving that her head injury "arose" out of her employment. *See* ORS 656.005(7)(a).

ORDER

The ALJ's order dated July 27, 1998 is affirmed.

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[1] OAR 438-007-0016 requires the parties to disclose "the identity of each expert witness the party will call to testify at the hearing." At the hearing, the ALJ has the discretion to allow testimony of expert witnesses who were not disclosed. Furthermore, in exercising this discretion, the ALJ "shall determine whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

In the Matter of the Compensation of
SHAWN L. RHOADES, Claimant
WCB Case No. 97-08354
ORDER ON REVIEW
Mark W. Potter, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that: (1) found that claimant had established good cause for his untimely hearing request; and (2) set aside SAIF's denial of his claim for a left knee injury. Claimant has included a newspaper article with his brief, requesting that we take "judicial notice" of the article. We treat this as a motion to remand for the taking of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand, timeliness of the request for hearing, and, potentially, compensability. We deny the motion to remand and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first full paragraph on page 2, we change the second sentence to read: "Claimant intended to respond to the call by driving to the main station. (Tr. 22, 45)." In the first paragraph on page 3, we delete the second sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant was a volunteer firefighter for the employer. He injured his left knee on November 19, 1996 while loading sandbags into his pick-up. Claimant signed an "801" form on November 22, 1996. (Ex. 2). SAIF denied the claim on April 21, 1997, on the basis that the injury did not arise out of or occur within the course of claimant's employment. (Ex. 4). Claimant received a copy of the denial on April 24, 1997. (Ex. 7-1, Tr. 16).

Claimant testified that he discussed the denial with the fire chief at that time, Mr. Connelly. Claimant said that Mr. Connelly said he would "talk to them and appeal it." (Tr. 16). Claimant's understanding was that either Mr. Connelly or the employer would take care of the denial. (Tr. 17, 29). Mr. Connelly retired June 15, 1997. (Ex. 7, Tr. 29).

On July 3, 1997, SAIF wrote to the employer, stating that the denial of the claim was final because it was not appealed. (Ex. 5).

Claimant prepared a statement with the help of the employer's executive secretary and his request for hearing was filed on October 14, 1997. (Ex. 7).

Remand

In his brief on review, claimant requests that the Board take "judicial notice" that 70 percent of all firefighters in Oregon are volunteers and that fire departments are struggling to recruit and keep volunteers. Claimant has included a copy of a newspaper article with his brief that discusses this situation. Because our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta at 1262.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988). Here, we find no compelling basis to remand because the newspaper article attached to claimant's brief is not reasonably likely to affect the outcome of the case. Accordingly, claimant's motion to remand is denied.

Furthermore, although we may, under limited circumstances, take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," *see Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985), we decline to take administrative notice of the newpaper article attached to claimant's brief. The Oregon Fire District Directors Association has also submitted a brief (which we have considered as an amicus curiae brief) that includes information similar to the article submitted by claimant. Under these circumstances, we decline to take administrative notice of the newspaper article.

"Good Cause"

The ALJ found that claimant had established excusable neglect for failing to file his hearing request in a timely manner. The ALJ reasoned that there was some confusion because of turnover of the secretarial position, the fire chief position and with some board members. The ALJ acknowledged that neither the current fire chief nor the secretary could explain exactly why the request for hearing was not filed in a timely fashion. Nevertheless, the ALJ believed that a reasonable inference could be drawn that the oversight was due to some degree of "shake up" in the office and not just simple negligence.

SAIF argues that claimant did not establish "good cause" for his failure to file his request for hearing in a timely manner. SAIF contends that there is no evidence that staff turnover had anything to do with claimant's failure to timely file his hearing request.

Claimant did not request a hearing on SAIF's April 21, 1997 denial until October 14, 1997, more than 60 days, but less than 180 days after SAIF's denial. (Ex. 7). A request for a hearing must be filed not later than the 60th day after the mailing of the denial to the claimant. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if the claimant establishes good cause for the late filing. ORS 656.319(1)(b). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). "Good cause" means "mistake, inadvertence, surprise or excusable neglect" as those terms are used in ORCP 71B. *Hempel v. SAIF*, 100 Or App 68, 70 (1990).

Citing *Voorhies v. Wood, Tatum, Mosser*, 81 Or App 336, *rev den* 302 Or 342 (1986), claimant argues that his reliance on his employer's assurances provided good cause for filing his request for hearing within 180 days. He asserts that the former fire chief assured him the employer would take care of the denial and he argues that the employer failed to do so because of extraordinary personnel changes. Claimant contends that, because of the assurances of the employer and because he knew similar claims had been previously handled by the employer, he did not appeal the denial.

In *Voorhies*, the insurer's claims supervisor erroneously advised the claimant that mailing a request for hearing on the 60th day would protect his rights. The court concluded that if the claims supervisor had not given the claimant erroneous information, he would have hand-delivered a request for hearing within the 60-day period. The court noted that the failure to meet a filing deadline was not accompanied by a lack of diligence or prejudice to the other party. 81 Or App at 340. Under these circumstances, the court concluded that the failure to file on the 60th day was excused by good cause. *Id.*

In the present case, the ALJ distinguished the *Voorhies* case on the basis that the claimant in *Voorhies* had relied on the representations of the *insurer's* claims supervisor. Here, in contrast, claimant is not relying on any representations made by SAIF. Rather, he is relying on representations made by the employer. Because there is no evidence that the employer was acting on behalf of SAIF in making any such representations, claimant's reliance on *Voorhies* is misplaced. Mr. Haugsness, the employer's fire chief since July 15, 1997, testified that SAIF makes the ultimate decision to accept or deny a claim. (Tr. 40). Mr. Haugsness did not understand why claimant was told that the employer would file the appeal for him or on his behalf, because his understanding was that claimant had to file the appeal himself. (Tr. 36).

Claimant also relies on *Freres Lumber Co. v. Jegglie*, 106 Or App 27 (1991), and argues that the employer's mistake caused the late filing of the request for hearing and that mistake constitutes good cause under ORS 656.319(1)(b). In *Jegglie*, the claimant failed to file a timely request for hearing because he believed that his attorney would handle the matter. The claimant's attorney had not received notice of the request for hearing and did not receive actual notice until after the 60 day period had expired. The court concluded that those circumstances constituted good cause under ORS 656.319(1)(b).

Here, in contrast, there is no evidence that SAIF failed to mail a copy of the denial to either claimant or the employer. Claimant was not represented by an attorney at the time SAIF issued the denial. Claimant testified that he received a copy of the denial and he discussed the denial shortly after he received it with the employer's former fire chief, prior to his June 15, 1997 retirement. (Tr. 16, 29). Because claimant received a copy of SAIF's denial, the *Jegglie* case is inapposite. Moreover, claimant testified that he was aware that an appeal had to be filed before he could contest SAIF's denial. (Tr. 25).

Claimant contends that this is not a case of simple negligence on the part of an employee. Rather, the upheaval and turmoil in the personnel at the employer was the cause of the appeal not being timely filed. Even if we assume, without deciding, that the employer was claimant's agent for purposes of filing the request for hearing, we are not persuaded that claimant has established "good cause" pursuant to ORS 656.319(1)(b).

In cases involving agents such as attorneys, the negligence of an attorney does not constitute good cause unless the attorney's reason for his or her action would be excusable if attributed to claimant. *Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977). In *Mendoza v. SAIF*, 123 Or App 349 (1993), *rev den* 318 Or 326 (1994), the claimant's attorney instructed his legal assistant to file a request for hearing, but she failed to do so. The Board concluded that those facts did not demonstrate "good cause" and the court affirmed, reasoning:

> "In this case, the attorney and the legal assistant were responsible for filing the request for hearing. The Board correctly concluded: '[B]ecause failure to request a hearing by someone charged with that responsibility is not excusable neglect, we hold that claimant has failed to establish good cause for his untimely request * * *.' We find no error." 123 Or App at 352-53.

In *Ogden Aviation v. Lay*, 142 Or App 469 (1996), the carrier's 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. The court found that, in contrast to the *Mendoza* case, there was no evidence that the claimant's attorney's secretary in *Lay* had any responsibility for filing hearing requests. *Id.* at 478. Rather, at most, the secretary was responsible for recognizing and handling notices of denial. The court affirmed the Board's conclusion that the claimant had shown good cause for the late filing.

Here, claimant's testimony indicates that the employer was acting as his agent for purposes of filing the request for hearing. Claimant testified that he was aware that an appeal had to be filed before he could contest SAIF's denial. (Tr. 25). As we discussed earlier, claimant said he discussed the denial with the former fire chief, Mr. Connelly, shortly after he received the denial and Mr. Connelly said that he would talk to SAIF and appeal the denial. (Tr. 16). Claimant's understanding was that either Mr. Connelly or the employer would take care of the denial. (Tr. 17, 29). Claimant testified that he followed up by asking Mr. Connelly about the appeal at a business meeting and Mr. Connelly told him he was still going to appeal the denial. (Tr. 25, 29).

Mr. Connelly was the fire chief at the time of claimant's injury on November 19, 1996 and he retired on June 15, 1997. (Ex. 7, Tr. 29). Mr. Connelly did not testify at the hearing and the record does not establish why he did not file claimant's request for hearing, if he in fact agreed to do so.

Ms. Spinks began working as the employer's executive secretary on December 12, 1996. (Tr. 31). She testified that she typed claimant's "801" form and mailed it to SAIF. (*Id.*) At a July Board meeting, she had heard that the employer would be handling claimant's appeal. (Tr. 32). Ms. Spinks did not know why the former fire chief did not pursue claimant's appeal. (Tr. 33). She was asked if Mr. Connelly was relatively busy before he retired and she replied:

> "I don't know. I don't know why it fell through the cracks. He was gone the whole month of May, and why -- that might have had something to do with it." (*Id.*)

Assuming that the employer was acting as claimant's agent for purposes of filing the hearing request, claimant's testimony indicates that Mr. Connelly was responsible for filing the hearing request. There is no evidence that Mr. Connelly delegated that responsibility to anyone else. Based on Ms. Spinks' testimony, the only explanation for Mr. Connelly's failure to file the request for hearing was

that he was gone in May 1997. However, that explanation only pertains to part of the 60 day time period following SAIF's denial. There is no explanation in the record as to why the request for hearing was not filed during the remaining 60 days after SAIF's April 21, 1997 denial. We find no evidence to support claimant's argument that "upheaval and turmoil" in the personnel at the employer was the cause of the appeal not being timely filed. Under these circumstances, we are not persuaded that claimant has established good cause for failing to file his request for hearing in a timely manner. *See Mendoza v. SAIF*, 123 Or App at 349; *EBI Companies v. Lorence*, 72 Or App 75, *rev den* 299 Or 118 (1985) (the negligence of the claimant's attorney's secretary did not excuse the primary negligence of the attorney); *Deanna L. Southerland*, 42 Van Natta 608 (1990) (no excuse was presented for the claimant's alleged agent's failure to file a timely request for hearing).

Claimant also contends that public policy requires that ORS 656.319 and the "good cause" standard should be liberally construed so that this matter is determined on the merits. Claimant relies on *Morrell v. Lane County*, 35 Or App 793 (1978).

Claimant's reliance on the *Morrell* case is misplaced. The *Morrell* case was not a workers' compensation case. Rather, the plaintiff in *Morrell* had filed a declaratory judgment proceeding. The issue was whether the court should grant or deny relief from default pursuant to *former* ORS 18.160. The court commented that the statute was to be "construed liberally to the end that the rights of litigants shall be determined on the merits of the controversy." *Id.* at 796. However, in *Brown v. EBI Companies*, 289 Or 455, 460 n.3 (1980), the Supreme Court distinguished *former* ORS 18.160 from ORS 656.319(1)(b):

> "One difference between [*former*] ORS 18.160 and ORS 656.319(1)(b), noted in *Sekermestrovich v. SAIF, supra,* is that [*former*] ORS 18.160, wisely or not, states relief from default judgments as a matter of the trial court's 'discretion,' while 'good cause' under ORS 656.319(1)(b) is not a matter of 'discretion' but of agency judgment in the sense stated in *McPherson v. Employment Division,* 285 Or. 541, 591 P.2d 1381 (1979)."

That distinction remains in the current version of ORS 656.319(1)(b). In other words, the text of ORS 656.319(1)(b) provides no basis for liberally construing the the "good cause" standard. Although previous case law provided that the Workers' Compensation Law was to be liberally construed in favor of the injured worker, *see Reynaga v. Northwest Farm Bureau*, 300 Or 255, 262 (1985), ORS 656.012(3) now requires the interpretation of Chapter 656 "in an impartial and balanced manner." We are not persuaded by claimant's argument that ORS 656.319 and the "good cause" standard should be liberally construed so that this matter is determined on the merits.

Finally, claimant argues that because SAIF failed to meet its timeliness requirements, it should not be allowed to hold claimant to strict compliance with the 60-day standard of ORS 656.319(1)(a). Claimant cites no authority for this argument. We acknowledge that SAIF's denial was issued after the 90-day period for issuing an acceptance or a denial. *See* ORS 656.262(6)(a). Nevertheless, we find no basis in the text or context of ORS 656.319 that provides that an untimely request for hearing may be excused by a late denial from the carrier.

In sum, we conclude that claimant has not established "good cause" for his untimely filing of a request for hearing. Accordingly, claimant's hearing request is dismissed.

ORDER

The ALJ's order dated June 1, 1998 is reversed. SAIF's denial is reinstated. The ALJ's attorney fee award is reversed. Claimant's hearing request is dismissed.

Board Chair Bock specially concurring.

Although I agree with the analysis in the lead opinion, I write separately to acknowledge the concern expressed by claimant and the Oregon Fire District Directors Association about the impact this case may have on the volunteer firefighter program. The fundamental "problem" for claimant in this case is that the record does not establish that extraordinary personnel turnover was the cause of the appeal not being timely filed. Rather, it appears that this is indeed a case of negligence. The Court of Appeals has concluded that the failure to request a hearing by someone charged with that responsibility is not excusable neglect. *Mendoza v. SAIF*, 123 Or App 349 (1993), *rev den* 318 Or 326 (1994). Although claimant has presented a sympathetic case, the evidence is simply insufficient to establish "good cause" for the failure to file a request for hearing in a timely manner.

Board Member Biehl dissenting.

Because I believe that the ALJ correctly found that claimant established "good cause" to justify his failure to timely file his request for hearing, I respectfully dissent.

The ALJ found, and I agree, that claimant has established something more than simple negligence on behalf of the employer, who had agreed to file his request for hearing.[1] Claimant testified that he had discussed SAIF's denial with Mr. Connelly, the fire chief at that time, shortly after he received it. (Tr. 16, 29). Claimant said that Mr. Connelly responded that he would "talk to them and appeal it." (Tr. 16). Claimant was aware that when claims had been denied in the past, the employer had discussed the situation with the insurer and the claims had been accepted. (Tr. 17). Claimant understood that either Mr. Connelly or the employer would take care of the denial for his case. (Tr. 17, 29). Claimant followed up by asking Mr. Connelly about the appeal at a business meeting and Mr. Connelly told him he was still going to appeal the denial. (Tr. 25, 29). Mr. Connelly retired June 15, 1997. (Ex. 7, Tr. 29).

I agree with the ALJ's conclusion that the oversight in filing claimant's request for hearing was due to turnover in the office and not just simple negligence. Claimant reasonably relied on the employer's assurances that the matter would be taken care of and appealed if necessary. Claimant's appeal deadline expired shortly after Mr. Connelly retired and before the new fire chief began working.

I believe that claimant has established mistake and excusable neglect for his failure to timely file his request for hearing. Accordingly, I would affirm the ALJ on this issue and address the merits of the claim. For these reasons, I respectfully dissent.

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[1] In reaching this conclusion, I disagree with the majority's conclusion that the *Voorhies*' rationale is not applicable. I acknowledge that *Voorhies* involved representations from an insurer, whereas the representations relied on by claimant were made by his employer. Nonetheless, I consider that distinction to be irrelevant, because the essential point remains that whether the representation came from the employer or its representative, claimant relied on the undisputed fact that the employer would "appeal" and "take care" of the denial. Consistent with the *Voorhies*' holding, such reliance constitutes "good cause" for an untimely hearing request.

In the Matter of the Compensation of
ALESIA K. SPENCER, Claimant
WCB Case No. 98-00870
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Marshall's order that set aside its denial of claimant's claim for a cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Inasmuch as claimant did not submit an appellate brief, no attorney fee shall be awarded for Board review. *Shirley M. Brown*, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated June 17, 1998 is affirmed.

Board Member Moller dissenting.

For the following reasons, I dissent from the majority's decision and would uphold the employer's denial of claimant's claim for a cervical condition.

Claimant asserts that her cervical condition was a consequence of her modified job duties following her compensable low back injury. Based upon this record, however, claimant's testimony regarding the onset of her neck and shoulder pain is not reliable. This point is illustrated by Exhibit 29A, one of Dr. Wong's chart notes. There, after receiving the employer's denial of her claim for neck and shoulder problems, claimant told Dr. Wong that her shoulder and neck symptoms began as a direct result of the original work injury on May 1, 1997. Claimant's statements to Dr. Wong in Exhibit 29A are contrary to claimant's testimony at hearing and the remainder of the documentary evidence. With the exception of Exhibit 29A, claimant had repeatedly attributed her neck and shoulder symptoms to her modified job duties following the May 1, 1997 injury and had not alleged that the symptoms arose directly as a result of the injury itself. The change in claimant's history to Dr. Wong appears to have been motivated by the employer's denial of the claim and the impending litigation.[1]

Other documentary evidence conflicts with claimant's testimony. Dr. Neumann noted that claimant initially reported to Dr. O'Neill that the neck and shoulder symptoms began after awakening from sleep following a visit to Dr. Tanabe in August 1997. (Exs. 8; 22). Thus, claimant's initial report did not implicate her modified job duties or the original injury as the cause of her symptoms. Given the discrepancies in the record, I am not persuaded that claimant's history to Dr. Wong was accurate. Under such circumstances, I would find Dr. Wong's opinion unpersuasive since it is based on an inaccurate history.

Finally, even if Dr. Wong's opinion was not based on an inaccurate history, his opinion is no better reasoned or explained than the contrary opinions of Dr. Neumann or Dr. Smith. For the reasons expressed in this dissent, I would uphold the employer's denial.

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[1] Dr. Wong reported that claimant "informs me that the insurer has denied compensability. Her attorney is appealing. *On further discussion*, she does state that she had onset of left-sided neck and shoulder pain when she sat down suddenly in her chair associated with her on-the-job injury." (Ex. 29A, emphasis supplied.)

November 30, 1998 Cite as 50 Van Natta 2263 (1998)

In the Matter of the Compensation of
DEBORAH A. ALLARD, Claimant
WCB Case No. 97-07415
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's current neck, shoulder and headache conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second sentence of the second paragraph on page 1, we change the date to "June 1996." We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on July 23, 1994, when she slipped and fell on her left shoulder. (Ex. 1). As a result of a stipulated settlement approved on February 6, 1995, the insurer accepted mild ulnar nerve palsy of left upper extremity, sprain/strain of pectoralis major and pectoralis minor shoulder girdle. (Exs. 18, 20). A Claim Disposition Agreement was approved on October 20, 1995. (Ex. 34).

After the injury, claimant had neck, shoulder and headache problems. She was diagnosed with, among other things, myofascial pain syndrome. (Exs. 21, 36, 37, & 59). On August 19, 1997, the insurer wrote to claimant, asserting that her accepted conditions were no longer the major contributing cause of her current need for treatment. (Ex. 61).

The ALJ relied on Dr. Grant's opinion and concluded that claimant's myofascial pain syndrome was the same condition as the accepted condition and that it was caused by the compensable injury. The ALJ also found that, based on the opinions of Drs. Falk and Giesen, claimant's headache condition was a compensable consequential condition.

The insurer argues that claimant's current medical treatment is not related to the accepted conditions and contends that the ALJ erred by relying on the opinions of Drs. Grant and Falk. On the other hand, claimant relies on Dr. Grant's opinion to argue that her myofascial pain syndrome is a "product" of the sprain/strain diagnosis and her headaches are a "by-product" of the myofascial pain syndrome.

We agree with the insurer that there is no medical evidence that claimant's myofascial pain syndrome and headaches are the same as the conditions accepted by the insurer, *i.e.*, mild ulnar nerve palsy of left upper extremity, sprain/strain of pectoralis major and pectoralis minor shoulder girdle. For the reasons that follow, we conclude that claimant has failed to establish the compensability of her myofascial pain syndrome and headaches.

Dr. Grant examined claimant on one occasion, almost three years after the compensable injury. He diagnosed the following conditions:

> "1. Chronic posttraumatic myofascial left neck, shoulder, periscapular, and upper extremity pain syndrome secondary to previous work injury. Unfortunately, this diagnosis is magnified significantly and inordinately by diagnosis number two below.
>
> "2. Chronic anxiety/adjustment reaction with mixed emotional features with heavy somatic preoccupation, over-dramatized pain behavior, multiple inconsistencies, and subjective complaints far outweighing objective findings." (Ex. 59-3).

We find that Dr. Grant's opinion that claimant's myofascial pain syndrome was "magnified significantly and inordinately" by a chronic anxiety/adjustment condition establishes that those two conditions "combined" to cause or prolong her disability or need for treatment. Dr. Grant agreed that his opinion regarding claimant's psychological condition was consistent with that of Dr. Fried, psychiatrist. (Ex. 66A-9).[1] Dr. Fried reported that claimant's personality features reflected long-term or chronic traits that had likely persisted for several years. (Ex. 45-5). He concluded that claimant had a somatization disorder that preexisted the work injury, as well as a conversion disorder. (Ex. 45-5, -6). Based on those medical opinions, we conclude that claimant's myofascial syndrome "combined" with a preexisting psychological condition. Therefore, even if we assume that claimant's myofascial pain syndrome arose directly from the work injury, the major contributing cause standard under ORS 656.005(7)(a)(B) applies to this case.

Under ORS 656.005(7)(a)(B), claimant must prove that the work injury was the major contributing cause of the myofascial pain syndrome. Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). The fact that a work injury precipitated a claimant's symptoms or condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.*

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[1] During a deposition, Dr. Grant reviewed Dr. Fried's report and said that Fried's references to a neurotic pattern of adjustment, somatization disorder and conversion disorder were generally consistent with his thoughts. (Ex. 66A-9). Dr. Grant commented that Dr. Fried, as a psychiatrist, was much more well-versed in diagnosing psychological conditions, but Dr. Grant said that he was picking up at least some of the general features that were enmeshed with claimant's pain complaints. (*Id.*)

Dr. Grant testified that claimant's myofascial pain syndrome was "significantly magnified" by the chronic anxiety/adjustment reaction with mixed emotional features. (Ex. 66A-7). He explained that the objective findings "loosely" documented the myofascial pain syndrome. (Ex. 66A-8). Dr. Grant said that, although sprains and strains generally recover within three to six weeks, a myofascial cycle of muscle tightness and pain can develop. (Ex. 66A-10, -11). He explained that factors such as physical stress, emotional stress, anxiety level and cold damp weather can feed into the cycle and keep it going. (Ex. 66A-11). Dr. Grant testified that the "anxiety neuroses and things like that will take what is physically there and amplify it either by 2 or by 102, depending on the psychiatric condition of the patient." (*Id.*) He agreed that claimant's work injury was the "triggering precipitating cause" of the myofascial condition. (*Id.*) He testified that the "injury that she described was *at least generally consistent* with a mechanism of injury that would bring about a problem of this type." (Ex. 66A-12; emphasis added). Dr. Grant testified that the treatment for claimant's myofascial condition was complicated by her underlying psychological condition. (Ex. 66A-16).

Dr. Grant's opinion is not sufficient to establish compensability for several reasons. Although Dr. Grant felt claimant's injury was "at least generally consistent" with causing myofascial pain syndrome, his opinion is not sufficient to establish compensability because it supports only a possibility that claimant's need for medical treatment for her current condition is related in major part to the compensable injury. This is insufficient to sustain claimant's burden of proof. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof).

Furthermore, Dr. Grant did not weigh the relative contribution from claimant's preexisting psychological condition and the work incident, nor did he explain whether or not the work injury contributed more to the claimed condition than the preexisting condition. In fact, his comments that claimant's myofascial pain syndrome was "magnified significantly and inordinately" by the chronic anxiety/adjustment condition indicate that claimant's psychological condition may be the major contributing cause of her current need for treatment. In addition, he explained that "anxiety neuroses and things like that" could take the physical condition and "amplify it either by 2 or by 102, depending on the psychiatric condition of the patient." (Ex. 66A-11).

Claimant also relies on Dr. Grant's opinion to argue that her headaches were caused in major part by the myofascial pain syndrome. Dr. Grant testified that he did not discuss what areas of claimant's head hurt or what brought on the headaches and he did not order any tests to differentiate between different types of headaches. (Ex. 66A-12, -13, -18). He commented, however, that most of the time headaches are related to the myofascial condition. (Ex. 66A-13). Dr. Grant's conclusory comment is not persuasive because it supports only a possibility that claimant's headaches are related to the compensable injury.

Although the ALJ relied on the opinions of Drs. Falk and Giesen to establish that claimant's headache condition was a compensable consequential condition, we do not find those opinions persuasive. In a check-the-box letter from claimant's attorney, Dr. Falk agreed that claimant's current headaches were caused in major part by the industrial injury and he noted that the myofascial pain syndrome creates spasm in cervical muscles. (Ex. 67). We are not persuaded by Dr. Falk's opinion because it is conclusory and lacks any analysis. He did not explain what type of headaches claimant was having and did not evaluate the relative contribution of other factors.

Dr. Giesen examined claimant on four of her visits to the emergency room. (Exs. 3, 19, 33, 42). On February 14, 1995, Dr. Giesen reported that there was no clear etiology of claimant's chronic headache, although he felt she had a combined tension migraine component. (Ex. 19). On June 11, 1996, he reported that claimant had a "[c]hronic headache with a combination of tension migraine, however, probably originating from the neck." (Ex. 42). Dr. Giesen's comment that claimant's headaches probably originated from her neck is not sufficient to establish a causal connection between her work injury and the headaches. Moreover, because Dr. Giesen did not evaluate the relative contribution of other possible causes of claimant's headaches, we conclude that his conclusory statement regarding her headaches is not sufficient to establish compensability.

In sum, we find no medical opinions that are sufficient to establish compensability of claimant's current shoulder, neck and headache conditions. Consequently, we conclude that claimant has not sustained her burden of proof.

ORDER

The ALJ's order dated July 30, 1998 is reversed. The insurer's denial of claimant's current shoulder, neck and headache conditions is reinstated and upheld. The ALJ's attorney fee is also reversed.

In the Matter of the Compensation of
CONCEPCION C. CANARIOS, Claimant
WCB Case Nos. 97-03225 & 97-02874
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

From 1992 through 1998, claimant worked as an eligibility specialist for the employer's public medical assistance program. Claimant contends that she developed a compensable depressive and anxiety disorder as a result of this employment. Specifically, claimant believes that her supervisors and manager have subjected her to racial discrimination, abuse, harassment and retaliation. Jean Thomas was claimant's direct supervisor until early 1996, when Colleen Russell became the acting supervisor. Ms. Thomas and Ms. Russell were managed by Kathleen Fuller-Poe. Ms. Thomas and Ms. Fuller-Poe are African-American. Claimant is Hispanic.

Specifically, claimant believes that management discriminated against her in making hiring and promotion decisions because she is not African-American. In 1992, Ms. Fuller-Poe offered claimant a part-time position in a North Portland clinic. Claimant declined the offer because she wanted full-time work. Shortly thereafter, the North Portland position was filled by an African-American woman, Robin Kelly, who was given a full-time schedule. Thereafter, claimant sought a promotion in 1994 and was placed on a list of qualified candidates based on testing, education, work experience and interviews. Claimant sought this promotion because she no longer felt challenged by the eligibility specialist job. Ms. Fuller-Poe ultimately filled the position with Robin Kelly, who had a higher ranking on the candidate list. Then, claimant was not given an opportunity to compete for Ms. Kelly's vacated eligibility specialist position in the North Portland clinic, which was filled by an African-American woman.

Claimant also believes that she was required to handle a heavier workload than her fellow eligibility specialists. The workload of all eligibility specialists increased dramatically with the implementation of the Oregon Health Plan in early 1994. But claimant believes that she was scheduled to see many more clients than the other eligibility specialist in the Northeast Portland Clinic, who was African-American. Claimant believes that she encountered the same inequitable work distribution after she transferred to the Southeast Portland Center in June 1994 and began working with Trish McClendon, an African-American woman. Claimant's interview schedule at the Southeast Portland site was double and triple-booked, whereas Ms. McClendon's was single-booked. This difference in scheduling continued after Ms. McClendon left in the fall of 1995 and was replaced by a series of new eligibility specialists who were also African-American.

Claimant's workload concerns intensified when she began experiencing chronic right arm and wrist pain in the fall of 1995. Claimant received treatment from Dr. Breen, M.D., who diagnosed a repetitive motion disorder. The employer accepted claimant's workers' compensation claim for this condition.

Claimant also believes that her managers were abusive and discriminatory in the manner in which they evaluated her performance. In 1992, claimant discovered that Ms. Thomas had placed memos regarding claimant's alleged poor performance in claimant's personnel file without her knowledge. Claimant complained of this matter to her union, and the memos were removed from claimant's file on the recommendation of the county's human resource manager. In addition, while annual performance evaluations were agency policy, claimant did not receive a single annual evaluation during her tenure as an eligibility specialist.

Claimant brought these workload, hiring and performance evaluation issues to the attention of Ms. Fuller-Poe, Ms. Thomas and Ms. Russell on numerous occasions. Claimant does not feel that the response she received from management was timely or adequate. Furthermore, she believes that she was subjected to further abuse, harassment and discrimination in retaliation for raising these issues. In particular, claimant notes that she did not receive a promotion to the supervisory position vacated by Jean Thomas in early 1996. Ms. Fuller-Poe did not post the position and, instead, appointed Colleen Russell as the acting supervisor. Ms. Fuller-Poe did so because she felt there was an immediate need to fill the position, and she chose Ms. Russell based on Ms. Thomas' recommendation and Ms. Russell's demonstrated leadership skills.

Claimant also criticizes management's response to work restrictions related to claimant's compensable right arm condition. By mid-December 1996, claimant's right arm and wrist symptoms had worsened to the point that Dr. Breen authorized light duty work. On or around December 18, 1996, the clinic manager, Richard Swift, asked claimant to interview an unscheduled "walk-in" client during time claimant had set aside for administrative matters. In response, claimant informed Mr. Swift of Dr. Breen's light duty work restriction. Mr. Swift than made remarks to claimant about the restriction and claimant's responsibility to handle unscheduled clients. Claimant felt that Mr. Swift acted in a demeaning and insulting manner, and without consideration for claimant's work restriction. Claimant spoke with Ms. Fuller-Poe and Ms. Russell about this incident and claimant's light duty work restriction. When the acting supervisor and manager did not follow up on this matter, claimant requested assistance from Dr. Breen. The treating physician intervened with the county, and on December 20, 1996, claimant was transferred to the Westside Clinic to assume a lighter caseload on a half-time schedule. When claimant filed a grievance regarding this incident with the clinic manager, a county investigator ultimately found no inappropriate conduct by the clinic manager. Claimant feels that she had no real input into this investigation.

Claimant experienced significant mental turmoil following the incident with Mr. Swift on December 18, 1996. When claimant saw Dr. Breen on January 3, 1997, she reported decreased interest in activities, insomnia, fatigue, diminished ability to concentrate and indecisiveness. On January 13, 1997, Dr. Lange, psychologist, evaluated claimant on referral from Dr. Breen. On January 14, 1997, claimant filed a mental stress claim with the employer. On January 20, 1997, Jeanne Ewen, LCSW, evaluated claimant on referral from Dr. Breen. Both Dr. Lange and Ms. Ewen diagnosed a depressive and anxiety disorder. Claimant has received psychological counseling from Ms. Ewen since January 1997. Claimant's treatment has also included anti-depressant medication.

After filing her mental stress claim, claimant continued to experience work incidents that she perceived as discrimination, retaliation and harassment. From late February through late April 1997, the employer placed claimant on a paid leave of absence. Claimant encountered further criticism regarding her performance when she returned to work. At that time, claimant experienced continuing right arm symptoms, and Dr. Breen considered claimant capable of doing "only what her job description requires, without excess." In June 1997, claimant received a written reprimand from Colleen Russell that addressed claimant's alleged insubordination and other performance issues. Claimant believed that the memo was unsubstantiated, and she requested that it be removed from her file. In August 1997, claimant filed a complaint with the county affirmative action office. An investigation ensued, and no substantial evidence of discrimination was found.

Meanwhile, on March 27, 1997, Dr. Klecan, psychiatrist, examined claimant on behalf of the employer. By letter dated April 11, 1997, the employer denied claimant's mental stress claim, and claimant requested a hearing. At the request of claimant's counsel, Dr. Johnson, M.D., evaluated claimant at some unspecified time prior to hearing.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she has established a compensable mental stress claim based on systematic abuse, harassment and racial discrimination over an extended period of time, including retaliation for raising these issues with her supervisors and manager. The ALJ concluded that claimant's mental stress claim was not compensable because the record does not establish that the alleged stressors exist in a real and objective sense and are not generally inherent in every working situation. We affirm the ALJ's ultimate conclusion and provide the following alternative analysis.

Claimant has the burden of affirmatively proving a compensable mental stress claim. ORS 656.266. To carry this burden, she must present persuasive evidence of a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community, and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(c) and (d). In addition, claimant must establish that employment conditions are the major contributing cause of the disorder. ORS 656.802(2)(a). In determining whether claimant has a compensable stress claim, we cannot consider: job stresses associated with conditions that do not exist in a real and objective sense; conditions generally inherent in every working situation; reasonable disciplinary, corrective or job performance evaluation actions by the employer; and cessation of employment or employment decisions attendant upon ordinary business or financial cycles. ORS 656.802(3)(a) and (b).

These diagnostic and causation issues involve 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). Medical evidence that does not factor out non-excluded employment conditions cannot satisfy a claimant's burden of proving a compensable mental disorder. *See Robert Jarvil*, 47 Van Natta 221 (1995); *Mary A. Murphy*, 45 Van Natta 2238 (1993).

Here, claimant relies on the opinion of Jeanne Ewen, LCSW, who has been counseling claimant since January 1997, and Dr. Johnson, M.D., who evaluated claimant at the request of her attorney. Counselor Ewen diagnosed a depressive and anxiety disorder that she related to specific working conditions, rather than off-work stressors. Dr. Johnson, M.D., completed a "check-the-box" opinion that claimant's job stressors were the major contributing cause of a diagnosable depressive and anxiety disorder.

The opinions of Dr. Johnson and counselor Ewen establish a diagnosable mental disorder. But they do not establish that the disorder is compensably related to work because they are based, in part, on stress associated with conditions that are generally inherent in every working situation. Specifically, both medical experts considered stress associated with claimant's perception that her supervisors and manager discriminated against her in hiring and promotion decisions because she was not African-American. The record does not establish, by clear and convincing evidence, that these hiring and promotion decisions are not generally inherent in every working situation. Because Dr. Johnson and counselor Ewen did not factor out this particular stressor, their opinions cannot be the basis of a compensable mental stress claim. *Accord Jarvil*, 47 Van Natta at 221; *Murphy*, 45 Van Natta at 2238.

In so concluding, we find that Ms. Fuller-Poe provided a reasonable response to claimant's contention that she was not offered a full-time position at the North Portland clinic in 1992 because she was African-American. Ms. Fuller-Poe explained that the North Portland eligibility specialist position did remain half-time, and the individual accepting that job also performed the duties of a separate position on a half-time basis. Ms. Fuller-Poe also explained that claimant did not receive the promotion she requested in 1994 because the position went to an individual with a higher ranking on the list of qualified candidates. Ms. Fuller-Poe also explained that she appointed Colleen Russell as acting supervisor in early 1996 because there was an immediate need to fill the position, and Ms. Russell had demonstrated leadership skills. Finally, we note that an investigation by the county affirmative action office in August 1997 found no substantial evidence of discrimination. On this record, we are not persuaded that stress associated with these hiring and promotion decisions is not a condition generally inherent in every working situation.

Finally, we note that Dr. Breen did not share the opinion of Dr. Johnson and counselor Ewen and, instead, concurred in the contrary opinion of Dr. Klecan that work stressors were not the major cause of any mental disorder claimant might be experiencing. Dr. Breen's concurrence is entitled to considerable weight, as he treated claimant from early January through August 1997 and has had the opportunity to observe and evaluate claimant on numerous occasions.[1]

For these reasons, we conclude that the medical record does not satisfy claimant's burden of proving that her diagnosed depression and anxiety is compensably related to her work for the employer. Consequently, we affirm the ALJ's ultimate decision to uphold the employer's denial of claimant's mental stress claim.

ORDER

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

[1] Dr. Lange also concurred with Dr. Klecan's opinion. Consequently, we give little weight to his earlier, inconsistent opinion that claimant's mental disorder is job related.

November 30, 1998 Cite as 50 Van Natta 2269 (1998)

In the Matter of the Compensation of
LINDA S. CLEMENS, Claimant
WCB Case No. 97-09705
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's right ankle injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On May 1, 1997, claimant, who was employed as a deli worker, filed a claim for a right leg injury that allegedly occurred on March 17, 1997 when she slipped and fell at work. Claimant sought treatment from Dr. Hayhurst on May 19, 1997, who diagnosed a probable right ankle sprain, slowly resolving. (Ex. 2).

On October 30, 1997, the employer denied the injury claim. Claimant requested a hearing.

Claimant's injury claim is not established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that claimant had sustained her burden of proving a compensable right ankle sprain. In doing so, the ALJ concluded that claimant had established medical causation based on Dr. Hayhurst's opinion and that this evidence was supported by "objective findings."

On review, the employer contends that claimant failed to prove legal and medical causation. Furthermore, the employer asserts that the claim should fail for lack of "objective findings." We do not find it necessary to address the employer's arguments regarding legal and medical causation because, even if claimant proved legal and medical causation, we agree with the employer that the medical evidence is not supported by "objective findings." We reason as follows.

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); *see Mark N. Weidle*, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

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."

Here, Dr. Hayhurst examined claimant one time on May 19, 1997. The examination was entirely normal, save for a slight limitation of eversion. (Ex. 2). Dr. Hayhurst later opined that, apart from the eversion finding, there were no objective finding to substantiate the existence of an ankle strain on a more likely than not basis. (Ex. 6-2). Moreover, Dr. Hayhurst agreed that he did not know the specific etiology of the eversion limitation, but that either the alleged work injury or a remote, non-work related medial malleolar fracture may have been the cause. According to Dr. Hayhurst, neither explanation was a probable cause of the limitation of motion. *Id.* In his deposition, Dr. Hayhurst could not be more definite regarding the cause of the eversion finding. (Ex. 7-9).

Based on our *de novo* review of Dr. Hayhurst's medical opinion, we are not persuaded that it establishes the presence of "objective findings" due to the alleged injury.[1] We also do not find the medical reports of two other physicians sufficient to prove the existence of objective findings due to the alleged injury. Dr. Nedrow examined claimant's foot on June 4, 1997 as part of a "get-acquainted visit." (Ex. 3). Claimant's examination was normal. On September 11, 1997, claimant saw Dr. Duwelius, who also reported a slight limitation of eversion, but did not attribute it to claimant's alleged work injury. (Ex. 4c).

To summarize, claimant's injury claim must be established by medical evidence supported by "objective findings." ORS 656.005(7)(a); *John G. Gesner*, 49 Van Natta 2147, 2148 (1997). Based on our review of the medical evidence, we find that the record does not contain sufficient evidence of "objective findings" causally related to the alleged injury. *Cf. Terry L. Sheeley*, 48 Van Natta 858, 859 (1996) (injury claim determined compensable when "objective findings" were due to alleged work incident). It follows that claimant's injury claim is not compensable.

ORDER

The ALJ's order dated June 11, 1998 is reversed in part and affirmed in part. The self-insured employer's October 30, 1997 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[1] We are mindful that a physical therapist reported findings such as "hypermobility" and reduced range of motion. (Exs. 2A, 4A). Dr. Hayhurst did not refer to or adopt the physical therapist's findings. Moreover, even assuming that the physical therapist's findings by themselves could constitute "objective findings," we agree with the employer that those findings are inconsistent with the other medical evidence; *e.g.* the physical therapist did not report the limitation of eversion and included findings that no physician reported. Accordingly, the physical therapist's report does not establish the existence of "objective findings" related to claimant's alleged injury.

In the Matter of the Compensation of
ERIC H. PATE, Deceased, Claimant
WCB Case No. 97-01503
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant's beneficiary requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial, on behalf of the alleged noncomplying employer, of claimant's fatal injury claim. On review, the issue is subjectivity.[1]

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[1] In his brief, claimant objects to admission of Exhibits 2-6 and 8-14. We do not address claimant's evidentiary objections because the disputed evidence is only relevant to the compensability issue, which we do not reach. *See* n. 2.

We adopt and affirm the ALJ's order,[2] with the following modification.

The second sentence on page four is modified to read: "A *worker* is any person who engages to furnish services for a remuneration, subject to the direction and control of an employer." *See* ORS 656.005(30).

We agree that, because claimant's beneficiary has not established that claimant was a "worker" at the time of the accident, claimant was not a "subject worker," and the denial must be upheld.

ORDER

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

[2] Claimant argues that the standard of proof is "clear and convincing" evidence under ORS 656.005(7)(b)(C). We note that the legislature changed that standard to a "preponderance" in 1995. *See Carolyne D. Florea*, 47 Van Natta 2020, 2022 (1995). But we do not reach the compensability issue, because we agree with the ALJ that claimant has not established that he was a subject worker when he died.

In the Matter of the Compensation of
IRIS K. SCOTT, Claimant
WCB Case No. 97-10026
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Bock and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that: (1) determined that the employer never filed a timely request for reconsideration of a Determination Order; and (2) vacated an Order on Reconsideration as having been invalidly issued. On review, the issue is the validity of the Order on Reconsideration and (potentially) scheduled permanent disability.

We adopt and affirm the ALJ's order, with the exception of the portion of the order that held, to perfect a valid request for reconsideration, the employer was required to satisfy OAR 436-030-0125 and OAR 436-030-0135. We do not adopt that portion of the ALJ's order because we find it unnecessary to decide the issue of whether compliance with those rules is a necessary prerequisite to filing a valid reconsideration request. In other words, we agree with the ALJ's alternative reasoning that the correspondence with the Department's Benefits Consultation Unit, which the employer asserts was a valid and timely request for reconsideration, was, in fact, not intended to be a request for reconsideration. (Ex. 103A).[1] Accordingly, we agree with the ALJ's decision to vacate the Order on Reconsideration.

Because the employer initiated the request for review and we have not reduced or disallowed claimant's compensation, 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

[1] After claimant requested a "lump sum" payment of permanent disability granted by a July 14, 1997 Determination Order, the employer sent a letter to the Department's Benefit Consultation Unit on September 9, 1997, stating that "We are objecting to the payment of the lump sum as we are requesting reconsideration of the Determination Order." (Ex. 103A). That same day, in a letter to claimant advising that it was objecting to a lump sum payment, the employer stated: "We are proceeding to request reconsideration of the Determination Order." (Ex. 103B). On September 30, 1997, more than 60 days after issuance of the Determination Order, the employer submitted a "Request for Reconsideration," which expressly challenged claimant's permanent impairment findings and scheduled permanent disability award. (Ex. 103C).

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 May 15, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

November 30, 1998 Cite as 50 Van Natta 2272 (1998)

In the Matter of the Compensation of
PAMELA G. WIMP, Claimant
WCB Case No. 98-00472
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of claimant's current lumbar disc condition. In its brief on review, the insurer asks the Board to either strike claimant's brief or review this matter without considering the discussion of factual matter and medical opinion not in the record. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order and write only to address the insurer's objection to claimant's brief. Claimant's brief is based, in part, on documents that are not admitted into evidence. In addition, claimant relies on a May 4, 1998 opinion from Dr. Calhoun that the ALJ excluded from the record at hearing.

Our review must be based on the record certified to us. *See* ORS 656.295(5). To the extent that claimant's brief discusses factual matter and medical opinion not in the record, we treat it as a motion to remand to the ALJ for the taking of additional evidence. Pursuant to ORS 656.295(5), we may remand if we find that the record has been insufficiently developed, and if the evidence claimant seeks to admit was not obtainable with due diligence at the time of the hearing. *Id. See also Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Here, we find that the new factual material and medical opinion discussed in claimant's brief was obtainable at the time of the hearing. Therefore, we deny claimant's motion to remand, and we do not consider any factual matter or medical opinion discussed in claimant's brief that is not already in the record. But we otherwise consider claimant's brief as an aid in our review to the extent it addresses factual matters and medical opinion in the record and presents arguments relevant to claimant's position that her current lumbar disc condition is compensable. Consequently, we deny the insurer's motion to strike claimant's brief.

ORDER

The ALJ's order dated June 29, 1998 is affirmed.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case No. 98-02326
ORDER ON RECONSIDERATION
Bottini, Bottini & Oswald, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

On October 20, 1998 we abated our September 24, 1998 Order on Review that reversed Administrative Law Judge (ALJ) Tenenbaum's order that set aside the insurer's March 17, 1998 partial denial of claimant's current condition. We took this action to consider claimant's motion for reconsideration and consolidation with WCB Case No. 98-04194. Having received the parties' supplemental briefing, we grant the consolidation request and proceed with our reconsideration.

In requesting reconsideration, claimant moved to consolidate review of this case with WCB Case No. 98-02326, which concerns the insurer's May 22, 1998 "pre-closure" current condition denial. As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). As claimant asserts, the two matters arise out of the same general circumstances and present issues that are inextricably intertwined. Both cases concern the procedural and substantive validity of the insurer's "pre-closure" denials of claimant's current condition as allegedly no longer compensably related to his accepted cervical and lumbar strains.[1] Because consolidation will further judicial economy and avoid potentially inconsistent rulings, we review the two cases together.

As a preliminary matter, it has come to our attention that our original order contains a clerical error. Specifically, in the first sentence of the fourth paragraph on page 1, we erroneously noted that claimant came under the care of Dr. Brett on October 7, 1997. The proper date is November 7, 1997.

In our original order, we disavowed *Robin W. Spivey*, 48 Van Natta 2363 (1996) and its progeny to the extent those cases held that ORS 656.262(7)(b)[2] applies only when the carrier has expressly accepted a combined condition. We concluded that, whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b) whenever 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. In so holding, we explained that if the medical evidence establishes a combined condition, the carrier is authorized (and, indeed, 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.

Upon finding that the insurer's March 17, 1998 current condition denial was procedurally appropriate (because it was based on medical evidence indicating that claimant's preexisting condition had combined with his accepted injury and asserted that the preexisting condition had become the major contributing cause of his prolonged disability and/or need for treatment), we proceeded to the merits. After considering the opinion of claimant's attending physician, Dr. Brett, along with the opinions of Dr. Bergquist and Dr. Hunt, we found the evidence insufficient to sustain claimant's burden. In other words, we were not persuaded that claimant's accepted lumbar strain remained the major cause of his disability and/or need for treatment as of March 17, 1998. We therefore upheld the insurer's current condition denial.

On reconsideration, claimant renews his contention that the insurer's March 17, 1998 denial was procedurally invalid. Specifically, claimant contends that the insurer's denial was impermissible because it denied claimant's entire current condition, including the accepted conditions, and not just a "combined condition." We disagree. Insofar as the insurer's March 17, 1998 denial acknowledged that the insurer had accepted (and would continue to pay all benefits related to) the cervical and lumbar strains claimant sustained in the October 16, 1997 work incident, the denial constitutes a partial denial

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[1] The pertinent facts are set forth in our original order, as well as in our order in WCB Case No. 98-04194, issued this date.

[2] This section provides: "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

and not a "back up" denial. It does not purport to deny conditions that have previously been accepted. Further, because the denial references medical evidence indicating that claimant's accepted injury combined with a preexisting condition to cause or prolong his disability and/or need for treatment and asserts that the accepted injury is no longer the major contributing cause of claimant's current condition, it is procedurally permissible and appropriate under ORS 656.262(7)(b).

Claimant also asserts that our construction of ORS 656.262(7)(b) is inconsistent with the court's comments in *SAIF v. Belden*, 155 Or App 568 (1998), and that it undermines the updated notice of acceptance requirement of ORS 656.262(7)(c).[3] Again, we disagree. As noted in our original order, we do not construe *Belden* as limiting the applicability of ORS 656.262(7)(b) to accepted combined conditions only. There, the court referred to an "accepted combined condition" in the context of ORS 656.262(7)(b) because the carrier had accepted a combined condition. The court held that, in the absence of a "pre-closure" denial of the claimant's current condition, all of the claimant's impairment from the combined condition was attributable to the compensable injury. *Belden* did not present the issue we resolve here.

Where a carrier issues an updated notice of acceptance at closure in compliance with ORS 656.262(7)(c) and a partial pre-closure denial in compliance with ORS 656.262(7)(b), a claimant is on notice of the accepted condition(s) as well as the denied condition(s). Contrary to claimant's contention, this process does not leave the worker to guess whether a "combined condition" has been accepted.[4]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 24, 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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[3] This section provides, in pertinent part, that when a carrier determines the claim qualifies for claim closure, the carrier "shall issue at claim closure an updated notice of acceptance that specifies what conditions are compensable."

[4] Indeed, if, after receiving the required statutory notice from the carrier, a claimant remains unsure as to whether the carrier accepted a combined condition, the claimant is authorized to object to the updated notice of acceptance and request clarification. ORS 656.262(6)(d), 656.262(7)(c).

Board Member Biehl dissenting.

As set forth in my and Member Hall's dissent to the original order, I continue to disagree with the majority's analysis and decision to disavow *Robin Spivey*, 48 Van Natta 2362 (1996) and its progeny. I believe that, if a carrier is going to take advantage of its right to deny a combined condition prior to closure under ORS 656.262(7)(b), it must have accepted that combined condition.

In the Matter of the Compensation of
TRACEY A. BLAMIRES, Claimant
WCB Case No. 98-04194
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its May 22, 1998 denial of claimant's current condition. Claimant cross-requests review, asserting that the "pre-closure" denial is procedurally invalid as well. While review was pending, claimant moved to consolidate this matter with our reconsideration of WCB Case 98-02326 (which concerns the insurer's March 17, 1998 "pre-closure" denial of claimant's current condition), asserting that the issues in both cases are inextricably intertwined. On review, the issues are consolidation and compensability. We grant the consolidation motion and reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact (with the exception of the ultimate findings of fact) and 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. (Exs. 1, 4, 6).

After treating with other medical service providers, claimant came under the care of Dr. Brett on November 7, 1997. (Exs. 10, 11). 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. (Ex. 14). The insurer accepted disabling cervical and lumbar strains. (Ex. 20).

In February 1998, Dr. Brett recommended an anterior lumbar interbody fusion at L4-5 and L5-S1 to address claimant's low back pain. (Ex. 24).

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 lumbar 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. (Ex. 29).

On March 17, 1998, the insurer issued an updated notice of claim acceptance and 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 and asserting that claimant's accepted conditions were no longer the major cause of his current disability and need for treatment. The insurer then closed the claim pursuant to a March 17, 1998 Notice of Closure which awarded temporary disability only. (Exs. 30, 31, 32).

In addition to challenging the insurer's partial denial (on both procedural and substantive grounds), 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. (Ex. 37).

Following a hearing concerning the insurer's March 17, 1998 partial denial, ALJ Tenenbaum issued an Opinion and Order on May 1, 1998 setting aside the denial as procedurally impermissible.[1] (Ex. 38). Thereafter, a May 21, 1998 Order on Reconsideration rescinded the Notice of Closure as premature. (Ex. 39).

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[1] This Opinion and Order was later reversed by the Board in *Tracey A. Blamires*, 50 Van Natta 1793 (1998), but the Board's Order on Review was then abated pending claimant's motion for reconsideration and consolidation with this proceeding.

On May 22, 1998, the insurer issued a second "current condition" denial. (Ex. 40). A few days later, the insurer issued an "Updated Notice of Acceptance At Closure," accepting a cervical strain and a lumbar strain combined with preexisting noncompensable degenerative disc disease. (Ex. 40A). Then, on May 28, 1998, the insurer closed the claim by Notice of Closure awarding temporary disability only. (Ex. 41).

CONCLUSIONS OF LAW AND OPINION

Motion to Consolidate

As noted above, claimant has moved to consolidate review of this case with WCB Case No. 98-02326, which concerns the insurer's March 17, 1998 "pre-closure" current condition denial. As a general rule, we will consolidate matters in which the issues are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), *aff'd* 139 Or App 512 (1996). In this case, the two cases arise out of the same general circumstances and present issues that are inextricably intertwined. Both cases pertain to the procedural and substantive validity of the insurer's "pre-closure" denials of claimant's current condition as allegedly no longer compensably related to his accepted cervical and lumbar strains. Consolidation will also further judicial economy and avoid potentially inconsistent rulings. Consequently, we grant claimant's motion and review the two cases together.

Procedural Validity of the May 22, 1998 Denial

The ALJ declined to address claimant's procedural challenge to the denial, noting that the parties' interests would be best served by resolving the compensability issue on the merits. On review, claimant renews his contention that the insurer's denial constitutes a procedurally impermissible "pre-closure" denial under cases such as *Elaine M. Borgelt*, 50 Van Natta 143 (1998) and *Michael C. Leggett*, 50 Van Natta 151 (1998). For the reasons set forth in our original order *Tracey A. Blamires*, 50 Van Natta 1793, as adhered to on reconsideration, 50 Van Natta 2273 (1998), we reject this argument.

In our original order in *Tracey A. Blamires* we revisited the "pre-closure" denial case law established by *Robin W. Spivey*, 48 Van Natta 2363 (1996) and its progeny (including *Elaine M. Borgelt* and *Michael C. Leggett*).[2] After considering the text and context of ORS 656.262(7)(b) as well as the legislative history underlying the 1995 statutory amendments, we found that the legislature specifically intended to overrule the "pre-SB 369" cases that viewed "pre-closure" denials as unauthorized attempts to circumvent ordinary claim closure procedures. We held that whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b) whenever 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. In so holding, we explained that if the medical evidence establishes a combined condition, the carrier is authorized (and, indeed, 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. On reconsideration, we adhere to this determination. *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998).

In this case, insofar as the medical evidence indisputedly establishes that claimant's compensable injury combined with his preexisting degenerative condition to cause or prolong his disability or need for treatment, the insurer's May 22, 1998 current condition denial was procedurally appropriate when issued.[3] As it did the first time around, the insurer proceeded precisely as contemplated by the current

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[2] These cases held that the "pre-closure" denial procedure set forth in ORS 656.262(7)(b) applied only when the carrier had expressly accepted a combined condition.

[3] As set forth above, the March 17, 1998 Notice of Closure had been rescinded as premature pursuant to a May 21, 1998 Order on Reconsideration. The Order on Reconsideration relied on ALJ Tenenbaum's May 1, 1998 Opinion and Order, which had set aside the insurer's first current condition denial as procedurally improper. Therefore, the claim was in open status at the time of the insurer's May 22, 1998 current condition denial.

statutory scheme. Prior to closing the claim, it issued an updated notice of acceptance as required by ORS 656.262(7)(c)[4] and a partial denial of claimant's current condition pursuant to ORS 656.262(7)(b).

Merits of the May 22, 1998 Current Condition Denial

Deferring to the opinion of Dr. Brett as claimant's attending physician, the ALJ determined that claimant's October 16, 1997 work injury remained the major contributing cause of claimant's current condition and need for surgery. The ALJ therefore set aside the May 22, 1998 denial insofar as it denied claimant's current low back condition. On review, the insurer contends that the denial should be reinstated, as Dr. Brett's causation opinion is unpersuasive. We agree with the insurer.

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.* "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).

As noted above, the medical evidence establishes that claimant's compensable injury combined with his preexisting degenerative disc disease to cause or prolong his ongoing disability and need for treatment. In Dr. Brett's opinion, claimant's work injury is the major contributing factor to claimant's current condition, because "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. 35-2).

On the other hand, Dr. Bergquist, who evaluated claimant on March 11, 1998, 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 explained that claimant's October 1997 work injury, which caused a low back strain but was insufficient to cause any acute changes or radiographic abnormalities, would be expected to resolve within a month or two, if not for the underlying degenerative changes. He concluded that claimant's work injury likely precipitated his need for treatment, but that the major contributing cause of claimant's current, ongoing low back complaints is his preexisting, idiopathic degenerative disc disease. (Ex. 29).

Although Dr. Brett is claimant's physician, we find persuasive reasons not to defer to his causation opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). As the insurer notes, Dr. Brett's opinion is lacking in explanation and analysis. Dr. Brett reports that claimant is likely experiencing discogenic pain at the L4-5 level, but his opinion does not evaluate the relative contribution of claimant's preexisting degenerative changes and does not explain why the work injury remains the primary cause of claimant's ongoing low back pain. Instead, Dr. Brett employs 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).

Consequently, on this record, we conclude that claimant has not established by a preponderance of the evidence that his compensable injury remained the major contributing cause of his disability or need for treatment at the time of the insurer's May 22, 1998 current condition denial. We therefore reinstate the insurer's partial denial.

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[4] Unlike the proceeding regarding the insurer's first "pre-closure" denial, the insurer's second "Updated Notice of Acceptance At Closure," issued May 26, 1998, indicated that the insurer accepted a combined condition. (Ex. 40A). But, given our determination in the first proceeding, it was not necessary for the insurer to accept the combined condition in order to take advantage of the right to deny claimant's combined condition under ORS 656.262(7)(b). *Tracey A. Blamires*, 50 Van Natta 1793 *on recon* 50 Van Natta 2273 (1998).

ORDER

The ALJ's order dated June 19, 1998 is reversed in part and affirmed in part. That part of the order that set aside the insurer's May 22, 1998 denial as to claimant's current low back condition is reversed, and the denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
CHERYL D. LARSSON, Claimant (aka CHERYL D. ADAMS)
Own Motion No. 98-0392M
OWN MOTION ORDER ON RECONSIDERATION
Travelers Group, Insurance Carrier

Claimant requests reconsideration of our September 30, 1998 Own Motion Order, in which we reopened claimant's claim for the payment of temporary disability benefits commencing July 8, 1998, the date claimant underwent surgery. Submitting a June 27, 1998 discharge summary, claimant contends that her temporary disability compensation benefits should begin on June 25, 1998, the date she was hospitalized for traction and pain management of her compensable condition. With her request, claimant also seeks "sanctions" for unreasonable claims processing.

On October 12, 1998, we abated our September 30, 1998 order in order to allow the insurer sufficient time to respond. Having received no response, we proceed with our reconsideration. After completing our reconsideration, we withdraw our prior order and replace it with the following order.

Entitlement to Temporary Disability Compensation

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

Here, as previously noted, a June 27, 1998 Discharge Summary documents that claimant was hospitalized on June 25, 1998 for treatment for her compensable condition. Inasmuch as this submission is not contested, we are persuaded that claimant's compensable condition worsened requiring the June 25, 1998 hospitalization. Thus, 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 June 25, 1998, the date claimant was first hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Penalties for Unreasonable Claims Processing

Claimant seeks "sanctions" apparently for the insurer's allegedly unreasonable delay in processing her own motion claim for temporary disability compensation. We interpret claimant to be requesting an assessment of penalties, based on the compensation "then due" at the time of the insurer's allegedly unreasonable conduct. *See* ORS 656.262(11); *Corrine Birrer*, 50 Van Natta 123 (1998).

A penalty may not be assessed under ORS 656.262(11) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. *Wacker Siltronic Corporation v. Satcher*, 91 Or App 654, 658 (1988); *Thomas L. Abel*, 44 Van Natta 1039, *on recon* 44 Van Natta 1189 (1992); *John D. McCollum*, 44 Van Natta 2057 (1992). At the time of Dr. Dunn's requests (which would constitute claimant's "own motion" request for claim reopening), claimant's claim was closed. When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim.

Here, the allegedly unreasonable conduct occurred prior to any order authorizing reopening of claimant's claim. Thus, because no compensation was due at the time of the insurer's allegedly unreasonable delay, a penalty could not be assessed under ORS 656.262(11). *Debra D. Robinson*, 49 Van Natta 786 (1997); *John D. McCollum, supra*; *Thomas L. Abel, supra*. Consequently, even assuming that the insurer's conduct was unreasonable, we would be without authority to assess a penalty.[1]

Accordingly, as supplemented and modified, we republish our September 30, 1998 order. 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] Claimant may wish to bring this matter to the attention of the Workers' Compensation Ombudsman. Should she wish to do so, the Ombudsman may be contacted free of charge at 1-800-927-1271, or at the following address:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97310

In the Matter of the Compensation of
GENE H. GOSDA, Claimant
WCB Case No. 96-03915
SECOND ORDER ON REMAND
Aller & Morrison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

On November 6, 1998, we withdrew our October 15, 1998 Order on Remand that set aside the insurer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. We took this action to consider claimant's contention that, in addition to the $4,301.25 awarded by the Court of Appeals, his counsel is entitled to $3,024 for services at hearing and $2,000 on Board review. Having received no response from the insurer within the time prescribed in our abatement order, we proceed with our reconsideration.

Where 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. ORS 656.388(1); *Mark L. Hadley*, 47 Van Natta 725 (1995). Apparently recognizing that authority to award an attorney fee for services rendered at the hearings, Board, and court levels would appear to rest with this forum (because claimant did not finally prevail until the issuance of the Order on Remand), the court has "conditionally" granted claimant a $4,301.25 fee for services rendered on judicial review. After considering the factors set forth in OAR 438-015-0010(4), we find that the court's $4,301.25 award (which neither party challenges) represents a reasonable fee for claimant's counsel's services performed before that forum.

Claimant also requests an attorney fee of $3,024 for services at the hearings level, (based on 16.35 hours of attorney time) and a fee of $2,000 for services on Board review.

The hearing took approximately two hours. Claimant was the only witness who testified. The record included 18 exhibits, including at least three submitted by claimant. The case involved legal issues associated with relying on the last injurious exposure rule in a compensability setting. The issue was more complex than those normally presented to this forum for resolution. Claimant's counsel submitted about 13 pages of argument on Board review.

The value of the interest involved in this case is significant in that claimant will likely receive compensation for medical services including surgery, temporary disability and, potentially, permanent disability for his compensable injuries. As demonstrated by the extent of litigation, there was a significant risk that claimant's counsel's efforts would go uncompensated. Finally, we note that the attorneys advocated their respective cases in a professional manner.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on Board review regarding the compensability issue[1] is $4,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's appellate arguments to the Board, and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated. This award is in addition to the $4,301.25 awarded for services performed before the court, resulting in a total award for services rendered before all prior forums of $8,801.25, to be paid by the insurer.

Accordingly, on reconsideration, we adhere to and republish our October 15, 1998 order, as supplemented and modified 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] Claimant is not entitled to an attorney fee for services devoted at the hearings level to the penalty issue. *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 461 (1986). Claimant did not pursue the penalty issue on Board Review.

In the Matter of the Compensation of
MICHELLE D. LIVINGSTON, Claimant
WCB Case No. 97-07711
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Sheridan & Bronstein, 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 denial of claimant's claim for a left arm condition. On review, the issue is compensability.

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

On review, the insurer renews its argument that claimant is not credible and accordingly, the history provided to her doctors was inaccurate. However, after reviewing the insurer's contentions, we agree with the ALJ that, while claimant's testimony and reports may not be precisely accurate, the record as a whole supports her testimony regarding an incident and/or exposure at work. Moreover, we do not find examples of material discrepancies which would undermine the ALJ's demeanor-based credibility finding. Accordingly, we agree with the ALJ that claimant has established compensability.

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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The ALJ's order dated July 7, 1998 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
PETER M. HURLIMAN, Claimant
WCB Case No. 98-00840
ORDER ON REVIEW
Adams, Day, Kangas & Vaneaton, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that concluded the Hearings Division did not have jurisdiction over claimant's hearing request regarding reimbursement of medical services and procedural temporary total disability (TTD) benefits. Claimant requests remand to the ALJ for further proceedings on the merits. In its brief on review, the SAIF Corporation joins claimant's request for review regarding jurisdiction over the procedural TTD issue. On review, the issues are jurisdiction, authority to award procedural TTD, remand and entitlement to procedural TTD. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," and we make the following additional findings. SAIF paid claimant procedural TTD for July 27 and 28, 1996. The treating physician released claimant to regular work as of August 19, 1996. On February 2, 1998, claimant requested a hearing regarding his entitlement to additional procedural TTD.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's conclusion that the Hearings Division does not have jurisdiction over claimant's request for hearing regarding reimbursement for medical expenses. *SAIF v. Shipley*, 326 Or 557 (1998) (Director has sole jurisdiction over request for hearing regarding medical services denied for a reason other than the formal denial of the compensability of the underlying claim); *Thurman M. Mitchell*, 47 Van Natta 1971 (1995) (Board does not have jurisdiction over disputes arising out of carrier's refusal to reimburse claimant for travel expenses associated with reasonable and necessary medical treatment of a compensable condition).

We turn to the parties' challenge to the ALJ's ruling that the Hearings Division does not have *jurisdiction* over claimant's entitlement to procedural TTD. The Hearings Division and Board are not *authorized* to impose an overpayment by awarding procedural TTD for time periods that have been substantively determined by a closure order. *Lebanon Plywood v. Seiber*, 1134 Or App 651 (1992). But we have *jurisdiction* over hearing requests regarding procedural TTD, even when the claim has been closed and substantive entitlement to temporary disability benefits determined. *Alfredo Martinez*, 49 Van Natta 67 (1997). Our jurisdiction in this matter arises from ORS 656.283(1), which provides that any party "may at any time request a hearing on *any matter concerning a claim*, except matters for which a procedure for resolving the dispute is provided in another statute[.]" (Emphasis supplied). *See also* ORS 656.704(3). Here, claimant's entitlement to procedural TTD is "a matter concerning a claim," and there is no other procedure for resolving this dispute.

Accordingly, we have jurisdiction in this matter, and the dispositive issue is whether we have the *authority* to award additional procedural TTD.[1] The present claim was in closed status on the date of hearing. But the following day the Department issued an Order on Reconsideration setting aside the closure.[2] The ALJ then reopened the hearing record to admit a copy of this reconsideration order. Thus, the claim was in open status when the hearing record closed, and when the ALJ issued his order. Under these circumstances, we conclude that the ALJ had the authority to address the merits of the procedural TTD issue.

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[1] In light of this conclusion, we need not address claimant's alternative argument that the Hearings Division and Board have jurisdiction because the request for hearing was filed when the claim was in open status.

[2] The April 24, 1998 Order on Reconsideration was not appealed and became final as a matter of law.

We turn to claimant's request for remand to the ALJ for further proceedings on the merits of the procedural TTD issue. 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). Here, the record was fully developed regarding the merits of the procedural TTD issue. Furthermore, pursuant to ORS 656.295(6), we have the authority to supplement or modify the ALJ's findings and conclusions. In light of this authority, we decline to remand this case to the ALJ, and we address the merits of the procedural TTD issue.

SAIF paid claimant procedural TTD for July 27 and 28, 1996. On review, claimant and SAIF agree that claimant is entitled to additional procedural TTD from July 29, 1996 through August 18, 1996. Claimant's entitlement to TTD for this period is supported by the record, including the treating physician's release to regular work as of August 19, 1996. Accordingly, claimant is entitled to further procedural TTD from July 29, 1996 through August 18, 1996.

ORDER

The ALJ's order dated June 5, 1998 is reversed in part and affirmed in part. The ALJ's jurisdictional ruling regarding the procedural temporary total disability issue is reversed. Claimant is awarded procedural temporary total disability compensation from July 29, 1996 through August 18, 1996. Claimant's attorney shall receive 25 percent of this increased compensation, payable directly to claimant's attorney, not to exceed $3,800. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GARY R. MYHRE, Claimant
WCB Case Nos. 97-04446 & 96-11354
ORDER ON REVIEW
Juli Point, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Connecticut Indemnity Company (Connecticut), on behalf of Springfield Forest Products, requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for a degenerative low back condition; (2) set aside its denial of claimant's occupational disease claim for a degenerative cervical condition; and (3) assessed a 10 percent penalty for Connecticut's allegedly unreasonable claims processing. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first full paragraph on page 5, we change the third sentence to read: "He had a visible bruise above his right hip and also on his back. (Tr. 73-74)." In the last paragraph beginning on page 5, we change the second sentence to read: "On November 7, 1996, Dr. Herring reported that the MRI showed central and right foraminal disc herniation at L3-4 with more widespread degenerative disc disease and bulging at L4-5 and L5-S1. (Ex. 35)."

In the second paragraph on page 10, we change the third sentence to read: "Dr. Young explained that the study 'shows that individuals who do strenuous physical activities in the rural low income setting such as farming and other laborious activities tend to have less symptoms than those who work in the higher income urban setting. (Ex. 84-3)." In the third paragraph on page 10, we change the first sentence to read: "On August 21, 1997, Dr. Goodwin opined that the May work injury caused a paravertebral strain that would heal in time. (Ex. 85A-1)."

In the first paragraph on page 11, we change the second sentence to read: "Dr. Beckwith agreed that during the October 17, 1996 examination he found tenderness in claimant's paravertebral muscles. (Ex. 94)." In the first full paragraph on page 12, we replace the fifth and sixth sentences with the

following: "Dr. Young opined that there was more evidence in medical literature and research showing that 'genetic factors are far more important in the evolution and development of degenerative disease than physical labor.' (Ex. 101-39)." In the second full paragraph on page 12, we change the third sentence to read: "During the deposition, Dr. Beckwith recalled that when he examined claimant on October 28, 1996, he noticed claimant had neck stiffness as well as a lower back strain. (Ex. 102-14)."

CONCLUSIONS OF LAW AND OPINION

Scope of December 10, 1996 Denial

The ALJ found that Connecticut's December 10, 1996 denial did not specifically deny claimant's "acute lower back" and it allowed a "de facto" denial to occur regarding the low back injury. The ALJ reasoned that the December 10, 1996 denial did not include a denial of lumbar spondylosis because the specific lumbar spondylosis claim had not been filed at the time the denial issued. The ALJ concluded that the lumbar spondylosis claim was "de facto" denied.

Connecticut argues that the ALJ erred by concluding that a claim had not been filed for claimant's degenerative condition at the time of the December 10, 1996 denial. Connecticut asserts that the December 10, 1996 denial included a lumbar degenerative condition because an "827" form signed by Dr. Beckwith on October 17, 1996 specifically diagnosed "peripheral neuropathy" and "spinal stenosis." For the following reasons, we agree with Connecticut.

On October 15, 1996, claimant signed an "801" form indicating that he had sustained a bruised lower torso on May 23, 1996. (Ex. 24). Dr. Beckwith signed an "827" form on October 17, 1996 diagnosing peripheral neuropathy and spinal stenosis. (Ex. 25). His chart note of the same date indicated that claimant was injured on May 23, 1996 when he was knocked over by a forklift. (Ex. 26-1). Dr. Beckwith indicated that claimant's condition looked like peripheral neuropathy, spinal stenosis and probable osteoarthritis. (Ex. 26-2). A lumbar spine study on October 17, 1996 showed mild degenerative narrowing of the L3-4 and L4-5 discs, degenerative spur formation throughout the lumbar spine and right L5 spondylosis. (Ex. 27).

In addition to Dr. Beckwith's October 17, 1996 report, there were other medical reports that referred to a degenerative lumbar condition before Connecticut issued the December 10, 1996 denial.

A lumbar MRI on November 4, 1996 showed degenerative disc disease at L3-4 with central and right foraminal disc hernation, degenerative disc disease, posterior apophyseal joint arthropathy and mild transverse lateral disc bulging at L4-5, and degenerative disc disease with mild transverse disc bulging at L5-S1. (Ex. 33). Dr. Goodwin examined claimant on November 18, 1996 and referred to severe cervical myelopathy and back problems that may be related to the May 1996 fall "and, to some degree, to his lumbar spondylosis." (Ex. 38-2).

On December 10, 1996, Connecticut wrote to claimant, indicating that it was in receipt of his claim for a "bruised lower back." (Ex. 41). Connecticut indicated that the medical information was insufficient to establish that the major cause of his current condition was his employment with Connecticut's insured. (*Id.*) On December 23, 1996, claimant's attorney filed a request for hearing on the December 10, 1996 denial.

On February 27, 1997, claimant's attorney wrote to Connecticut, formally requesting acceptance of lumbar spondylosis, as an "occupational disease or worsening of a preexisting disease process[.]" (Ex. 60B-1).

This is an initial claim for compensation. 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. *Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227 (1992). In *Garnet D. Toll*, 50 Van Natta 1346 (1998), we acknowledged 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, we concluded that ORS 656.262(7)(a) did not apply to an *initial* claim for compensation. *Id.* at 1347.

Here, claimant's "801" form referred to a bruised lower torso sustained on May 23, 1996. (Ex. 24). Dr. Beckwith's "827" form diagnosed peripheral neuropathy and spinal stenosis. (Ex. 25). His chart note of the same date indicated claimant's condition looked like peripheral neuropathy, spinal stenosis and probable osteoarthritis. (Ex. 26-2). A lumbar spine study showed degenerative lumbar conditions, as did a November 4, 1996 MRI. (Exs. 27, 33). Dr. Goodwin's November 18, 1996 report referred to claimant's lumbar spondylosis. (Ex. 38).

Under these circumstances, we conclude that claimant's claim for a bruised lower torso included lumbar spondylosis. Moreover, we conclude that Connecticut's December 10, 1996 denial, which referred to the claim for a "bruised lower back" and denied the "current condition" on the basis of causation, was sufficient to raise a causation issue with respect to all unaccepted low back conditions, including the lumbar spondylosis. Because claimant's initial claim already included a claim for lumbar spondylosis, it was not necessary for him to file a separate formal request for acceptance of lumbar spondylosis. (Ex. 60B). Thus, we do not agree with the ALJ's conclusion that Connecticut "de facto" denied a claim for lumbar spondylosis.

Scope of April 16, 1997 Denial

The ALJ found that claimant's degenerative cervical condition, including cervical spondylosis and a bone spur condition was never expressly accepted or denied and those conditions were "de facto" denied by Connecticut. The ALJ reasoned that Connecticut denied a "current condition" in the April 16, 1997 denial, but that was not the same as expressly denying specifically enumerated conditions.

For the following reasons, we conclude that Connecticut's April 16, 1997 denial included a denial of claimant's degenerative cervical conditions.

On January 21, 1997, claimant's attorney wrote to Connecticut, requesting acceptance of "[p]rogressive cervical spondylosis disease process" and "[s]evere cervical myelopathy." (Exs. 38AAAA, 49). The letter referred to Dr. Goodwin's November 18, 1996 report. Claimant's attorney explained:

> "The worker believes these conditions may have been incorrectly omitted from the above-referenced claim in that the incident resulting in an accepted claim for 'bruised back' may have worsened [claimant's] preexisting condition. The above conditions are also asserted as compensable occupational diseases. The worker hereby also asserts a claim for the above conditions as new medical conditions and requests formal written acceptance of these conditions." (*Id.*)[1]

There are two exhibits from Dr. Goodwin dated November 18, 1996. One is a chart note and one is a letter from Dr. Goodwin to Dr. Herring. (Exs. 38, 39). Claimant did not specify in the January 21, 1997 letter if he was referring to the chart note or the letter. The November 18, 1996 chart note reported that claimant had "[s]evere cervical myelopathy that has worsened." (Ex. 38-2). Dr. Goodwin commented that this was secondary to large spurs at C3-4 and C5-6 and he felt that claimant's "progressive cervical spondylosis disease process" was secondary to claimant's years of work. (*Id.*) Dr. Goodwin's November 18, 1996 letter said that claimant had severe cervical spondylosis and resultant myelopathy. (Ex. 39).

On April 16, 1997, Connecticut wrote to claimant, acknowledging that it had received his claim for a "cervical spondylosis and bone spur condition[.]" (Ex. 66). The letter denied the claim on the basis that the "information received is insufficient to establish that the major cause of your current condition is your employment[.]" (*Id.*)

Connecticut's April 16, 1997 denial specifically referred to claimant's claim for a cervical spondylosis and bone spur condition and went on to deny compensability of his "current condition" on the basis of causation. We conclude that Connecticut's April 16, 1997 denial included a denial of claimant's cervical spondylosis and cervical bone spurs. Moreover, because both of Dr. Goodwin's November 18, 1996 reports referred to claimant's cervical myelopathy and claimant specifically referred to Dr. Goodwin's November 18, 1996 report in the January 21, 1997 request for acceptance, we conclude that Connecticut's April 16, 1997 denial also included a denial of cervical myelopathy. We reject claimant's argument on review that the cervical myelopathy claim was not addressed in Connecticut's second denial.

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[1] We note that, although claimant's January 21, 1997 letter referred to an "accepted claim for 'bruised back[,]'" Connecticut did not accept a bruised back. As we discussed earlier, this is an initial claim for compensation.

Compensability

Injury Theory - Neck

The ALJ found that claimant had not filed a claim for a neck injury and, for that reason, did not analyze compensability for that condition. We agree with the ALJ's conclusion. Claimant's "801" form signed on October 15, 1996 refers to a "bruise" of the lower torso. (Ex. 24). Dr. Beckwith's "827" form dated October 17, 1996 referred to peripheral neuropathy and spinal stenosis. (Ex. 25). His chart note of the same date referred to claimant's low back pain and right thigh and foot pain. (Ex. 26). We agree with the ALJ that claimant did not file a claim for a neck injury.

Injury Theory - Back

At hearing, claimant argued that he sustained, at a minimum, a back strain as a result of the May 23, 1996 forklift incident. (Claimant's closing argument at 9). The ALJ concluded that claimant failed to prove he sustained a compensable injury to his back. Although we agree with the ALJ's conclusion, we provide the following analysis.

Claimant testified that on May 23, 1996, he was struck by a load of veneer that was being transported by forklift. (Tr. 73, 74). This incident was witnessed by other coworkers and was reported to the employer. (Tr. 25-27, 43-45, Ex. 34). Claimant was taken to the break room and went home for the rest of the day. (Tr. 45-46, 106). Claimant did not seek medical treatment and went back to his regular work on the following Monday. (Tr. 74, 106). Claimant testified that he went to the doctor in October 1996 because the weather changed and he had more pain. (Tr. 75).

On October 17, 1996, Dr. Beckwith reported that within the first month after the May 1996 injury, claimant noted some low back pain and numbness and pain in the right leg, thigh and foot. (Ex. 26-1). Dr. Beckwith said it looked like claimant had peripheral neuropathy, spinal stenosis and probable osteoarthritis. (Ex. 26-2).

An imaging study of the lumbar spine on October 17, 1996 showed mild degenerative narrowing of the L3-L4 and L4-L5 discs, degenerative spur formation throughout the lumbar spine and right L5 spondylosis. (Ex. 27). A lumbar MRI on November 4, 1996 showed degenerative disc disease at L3-4 with central and right foraminal disc hernation, degenerative disc disease, posterior apophyseal joint arthropathy and mild transverse lateral disc bulging at L4-5, and degenerative disc disease with mild transverse disc bulging at L5-S1. (Ex. 33)

The medical evidence establishes that claimant's degenerative low back condition preexisted the May 1996 forklift incident at work, and constitutes a "preexisting condition" pursuant to ORS 656.005(24). (Exs. 53, 57-8, 60, 62). Furthermore, the medical evidence establishes that claimant's compensable injury combined with the preexisting degenerative condition to cause or prolong his disability or need for treatment. (Exs. 53, 62). Therefore, claimant must establish that his compensable injury was the major contributing cause of his current disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B).

Considering the passage of time before claimant sought treatment and because there are multiple potential causes for his low back condition, determination of the cause of claimant's low back injury is complex and requires expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

On August 21, 1997, Dr. Goodwin opined that claimant's work injury in May 1996 "would cause a paravertebral strain." (Ex. 85A-1). He commented that "[t]his would heal with time and this is not related to the diseases which are currently disabling to him which are related to lumbar spondylitic processes." (*Id.*) On September 1, 1997, Dr. Beckwith agreed with Dr. Goodwin's "postulation" that the May 1996 incident caused a paravertebral strain. (Ex 94). Drs. Stanford and Watson diagnosed "lumbar strain phenomena reported October 1996 in relation to on-the-job injury May 1996." (Ex. 59-6). Dr. Rosenbaum diagnosed a "[p]ossible chronic lumbar strain." (Ex. 65-6). He commented that one could assess that claimant may have developed a mild lumbar strain associated with the May 1996 incident. (*Id.*)

We find that the medical opinions "postulating" that claimant sustained a lumbar strain as a result of the May 1996 injury are not sufficient to establish compensability because they support only a *possibility* that claimant sustained a lumbar strain. This is insufficient to carry claimant's burden. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). In light of claimant's delay in seeking treatment after the May 1996 incident and the lack of persuasive medical evidence regarding a strain, we are not persuaded that claimant sustained a lumbar strain.

Even if we assume, without deciding, that claimant sustained a lumbar strain as a result of the May 1996 incident, we are not persuaded that the work incident was the major contributing cause of claimant's disability or need for treatment in October 1996. In closing argument, claimant relied on Dr. Goodwin's January 30, 1997 opinion:

> "Based on his history, his lumbar pain and need for treatment from the lumbar condition is related to his work injury of May of 1996. The back condition most certainly did pre-exist the May 1996 fall. Lumbar spondylosis is a slowly progressive condition, similar to cervical spondylosis. The fall in May of 1996 was the cause of increasing back pain. This was the major cause of his need for treatment." (Ex. 53).

Although Dr. Goodwin's January 30, 1997 report focused on the May 1996 incident as the major cause of claimant's need for treatment, he did not comment on the fact that claimant did not seek medical treatment until October 1996. Furthermore, Dr. Goodwin's January 30, 1997 report is inconsistent with his August 21, 1997 report indicating claimant's strain "would heal with time." (Ex. 85A). In the August 21, 1997 report, Dr. Goodwin said that a paravertebral strain "would heal with time and this is not related to the diseases which are currently disabling to him, which are related to lumbar spondylitic processes." (Ex. 85A-1). In that report, Dr. Goodwin explained that claimant's "lumbar pain also is caused by his work experiences from an occupational disease standpoint rather than a specific injury." (*Id.*) Thus, it appears that Dr. Goodwin changed his opinion on causation of the lumbar condition during the course of treatment. In light of Dr. Goodwin's August 21, 1997 report, we are not persuaded that the May 1996 injury was the major contributing cause of claimant's disability and need for treatment.

Occupational Disease Theory

The ALJ relied on the opinions of Drs. Goodwin, Herring and Beckwith and concluded that claimant's life-time work activities were the major contributing cause of his degenerative neck and back conditions.

On review, Connecticut argues that the opinions of Drs. Goodwin, Herring and Beckwith are insufficient to establish compensability. Connecticut contends that claimant did not prove that his work activities were the major contributing cause of his cervical and lumbar degenerative conditions.

Claimant relies on the last injurious exposure rule of proof to establish compensability of his occupational disease claims for degenerative cervical and lumbar conditions. He contends that those conditions were caused in major part by his employment activities with Georgia-Pacific[2] and Connecticut's insured. In 1958, claimant began working for Georgia-Pacific. (Tr. 58). Except for a few short periods of employment elsewhere, he worked for Georgia-Pacific until 1989. He then began working for Connecticut's insured until 1996, performing the same work. (Tr. 61). During the course of his employment, he worked on the green chain, the glue line, as a clipper operator and as a chaser. (Tr. 62). Each position required repetitive use of his neck and back. (Tr. 63-67).

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[2] Although claimant originally filed a claim with Georgia-Pacific, the ALJ granted Georgia-Pacific's motion to dismiss claimant's request for hearing regarding Georgia-Pacific. The ALJ's determinations in WCB No. 96-11354 and dismissal of claimant's request for hearing in WCB No. 97-04446 were contained in one final, consolidated order. On review, Georgia-Pacific sought dismissal of Connecticut's appeal insofar as it pertained to WCB No. 97-04446. However, because the ALJ's consolidated order was appealed, we denied Georgia-Pacific's motion to dismiss. *Gary R. Myhre*, 50 Van Natta 1103 (1998). We noted, however, that since none of the parties apparently wished to contest the ALJ's decision regarding WCB Case No. 97-04446, any issue arising from the ALJ's dismissal of claimant's hearing request in that case would not be considered on review unless subsequently raised by one of the parties. None of the parties have contested the ALJ's dismissal of Georgia-Pacific.

To establish an occupational disease, claimant must prove that his employment conditions were the major contributing cause of his lumbar and cervical degenerative conditions. *See* ORS 656.802. The last injurious exposure rule of proof allows a claimant to prove the compensability of an occupational disease without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the claimant's condition. *Roseburg Forest Products v. Long*, 325 Or 305, 309 (1997) (citing *Runft v. SAIF*, 303 Or 493, 500 (1987)). The claimant need prove only that the disease was caused by employment-related exposure. *Id.*

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). Where the medical evidence is divided, we generally 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).

Claimant relies primarily on the opinion of Drs. Goodwin and Herring, his treating physicians, to establish compensability. In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, we find that the dispute (*i.e.*, whether claimant's lumbar and cervical degenerative conditions are compensable) involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979).

After considering the expert medical evidence, we conclude that claimant has failed to prove that his employment activities are the major contributing cause of the lumbar and cervical degenerative conditions. At best, we find that the medical evidence is in equipoise.

Dr. Herring's opinions on causation are inconsistent. On June 26, 1995, he reported that, without a specific incident of trauma, it would be hard to "pin" claimant's cervical myelopathy and spondylosis to his work activities. (Ex. 17). On October 28, 1996, he commented that it appeared claimant was "disabled as a result of progressive illness, not as a result of work related injury, and he is advised to pursue social security disability." (Ex. 32-3). In contrast, Dr. Herring subsequently concurred with Dr. Goodwin, who believed that claimant's work activities were the major contributing cause of his degenerative conditions. (Exs. 54, 75, 76, 77, 95). Because Dr. Herring did not explain his apparent change of opinion regarding causation of claimant's degenerative conditions, we do not find his opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Claimant's original treating physician was Dr. Beckwith. Although Dr. Beckwith offered some opinions on causation, he subsequently indicated that the etiology of the degenerative conditions was not an area of his expertise and he preferred not to offer any specific opinion on that question. (Exs. 78, 102-15). For that reason, we do not rely on Dr. Beckwith's opinions on causation.

Dr. Goodwin believed that the primary cause of claimant's degenerative lumbar and cervical conditions was his work activity in the wood products industry. (Exs. 61-1, 62). Dr. Goodwin explained that claimant has always been employed in repetitious jobs such as pulling greenchain and he was aware that such work involved a constant right-to-left twisting and turning of the neck. (Ex. 72-1). He felt that the work of a greenchain puller was one of the most stressful jobs for the cervical spine and claimant's heaviest and most repetitive work was at Georgia-Pacific and Connecticut's insured. (Ex. 85A-1, -2). Dr. Goodwin also acknowledged the contribution of general aging and genetic issues to claimant's degenerative conditions, but he concluded that the major contributing cause was the work activities. (Ex. 85A).

Connecticut relies on the opinions of Drs. Young, Stanford, Watson, Zivin and Rosenbaum to argue that there is no scientific support for the proposition that work activity causes more degeneration than non-work activity. Drs. Watson, Stanford, Zivin and Rosenbaum each opined that they were not aware of any scientific studies correlating work activities and degenerative conditions. (Exs. 65-8, 71-11, 73, 84A, 99-32, -35, 100-23). They did not believe that claimant's years of heavy physical labor was causative of his degenerative cervical and lumbar conditions.

Dr. Rosenbaum explained that the degenerative osteoarthritis is a progressive condition that involves an interplay between genetic predisposition and environmental factors. (Ex. 73). However, he felt that repetitive heavy physical work was *not* an etiology of degenerative osteoarthritis. (*Id.*) Dr. Rosenbaum said that the medical literature has not been able to correlate a patient's work activities with the progression of spondylosis. (Exs. 65-8, 73).

Dr. Zivin reported that genetic issues determine the degree, intensity, speed and distribution of degeneration. (Ex. 71-11). He said that nothing in the medical literature showed that ordinary work creates or intensifies the degeneration. (*Id.*) Likewise, Dr. Young disagreed with Dr. Goodwin's opinion that claimant's degenerative changes were related to his work activities, stating that theory was "unsubstantiated by facts, medical research and clinical practice." (Ex. 84-2). Dr. Stanford had never heard of a study linking lumbar or cervical degenerative changes to work activities. (Ex. 99-32, -35). In fact, he said that he had severe degenerative arthritis and had never worked at a heavy job. (Ex. 99-35). Dr. Watson testified that it was speculative whether any heavy labor could cause or worsen degenerative disease. (Exs. 100-23, -24).

After reviewing the reports from Drs. Zivin and Rosenbaum, Dr. Goodwin said that the only disagreement he had with them was whether "30 some years" of physical labor could cause cervical spondylosis. (Ex. 72-1). Dr. Goodwin explained that, based on the lifetime activities claimant described, he felt that claimant's work activities constituted the greater part of his physical exertions, and that was why he concluded that work was the major cause of the cervical spondylosis. (Ex. 72-1, -2). He also felt that claimant's work activities were the major cause of the lumbar degenerative disease. (Ex. 85A). Dr. Goodwin's opinions regarding the occupational disease claim are conclusory and lack adequate explanation.

In sum, after reviewing the record, we find that the opinions of Drs. Goodwin and Herring are no more persuasive than the other medical opinions. At best, the record is in equipoise. Consequently, claimant failed to carry his burden of proving the compensability of his cervical and lumbar degenerative conditions.

Penalties

The ALJ assessed a 10 percent penalty for Connecticut's allegedly unreasonable claims processing. The ALJ acknowledged that there was medical evidence to permit Connecticut to have a legitimate doubt as to compensability of the claims. Nevertheless, the ALJ found that both of Connecticut's denials "missed the mark" as to what was being claimed at that point in time. The ALJ found that the December 10, 1996 denial never accepted or denied a bruised lower back and it apparently attempted to deny the existence of a degenerative condition for which no claim had yet been filed. The ALJ reasoned that the April 16, 1997 denial did not specifically accept or deny cervical spondylosis and bone spur conditions, but focused on a "current condition." The ALJ concluded that the status of the claims was very confusing because of the way in which the claims were processed/ not processed and he held that the claims processing was "incorrect and unreasonable."

On review, we have determined that the underlying claims are not compensable. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.[3]

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[3] Because of our conclusion that there is no evidence of unpaid compensation, we need not determine whether the insurer's conduct was unreasonable. Were we to address the issue, however, we would reach the following conclusions.

As we discussed earlier, we do not agree with the ALJ's conclusion that Connecticut "de facto" denied lumbar spondylosis or cervical spondylosis and bone spur conditions. We found that Connecticut's December 10, 1996 denial included a denial of claimant's low back conditions, including a "bruised lower back" and degenerative back conditions, including lumbar spondylosis. Furthermore, we concluded that Connecticut's April 16, 1997 denial included a denial of claimant's degenerative cervical conditions, including cervical spondylosis and cervical myelopathy. In any event, even if we reached a different conclusion regarding the scope of the December 10, 1996 and April 16, 1997 denials, we would conclude that Connecticut had a legitimate doubt that it had already denied claimant's degenerative lumbar and cervical conditions.

Furthermore, based on the reports from Drs. Young, Watson, Stanford, Rosenbaum and Zivin, we find that Connecticut had a legitimate doubt as to its liability for claimant's degenerative cervical and lumbar conditions. Therefore, Connecticut's refusal to accept the claims was not unreasonable, and a penalty or penalty-related fee is not warranted.

ORDER

The ALJ's order dated April 21, 1998 is reversed in part and affirmed in part. The portions of the ALJ's order that set aside "de facto" denials of claimant's lower back bruise/strain/sprain, degenerative lumbar condition and degenerative neck condition are reversed. The portion of the ALJ's order that set aside Connecticut's denial of claimant's degenerative cervical and lumbar conditions is reversed. Connecticut's denial of those conditions is reinstated and upheld. The ALJ's assessment of a penalty for Connecticut's allegedly unreasonable claims processing is reversed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

December 3, 1998 Cite as 50 Van Natta 2289 (1998)

In the Matter of the Compensation of
DARRELL J. MOULTON, Deceased, Claimant
WCB Case No. 98-00554
CORRECTED ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

It has come to our attention that our November 25, 1998 order contains an error. Specifically, the first sentence in the first paragraph that reads "Claimant requests review of Administrative Law Judge (ALJ) Herman's order that *set aside* insurer's denial* * *" should have read "*upheld* the insurer's denial of a fatal injury claim." To correct this oversight, we withdraw our prior order and replace it with the following order.

Claimant[1] requests review of Administrative Law Judge (ALJ) Herman's order that set aside the insurer's denial of a fatal injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 1, 1998 is affirmed.

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[1] Claimant is deceased and represented in these proceedings by his beneficiary. However, for ease of reference, we shall use the word "claimant" rather than "claimant's beneficiary" in our order.

In the Matter of the Compensation of
FRANK M. DIONNE, Claimant
WCB Case No. 98-00857
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denials of claimant's current low back condition, degenerative disc disease at L4-5 and L5-S1, and anterolisthesis at L5-S1. On review, the issue is compensability.

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

Applying *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), the ALJ found compensable claimant's L4-5 disc herniation condition and his L5-S1 spondylolisthesis condition (also referred to in the medical record as "anterolisthesis"). In addition, on the merits, the ALJ found compensable claimant's L4-5 and L5-S1 degenerative disc disease condition. On review, the insurer disputes those findings and argues that *Piwowar* does not apply to this claim because there was no specification of the condition accepted on the notice of acceptance. While we agree with the insurer that when an acceptance does not identify the specific condition, we generally look to the contemporaneous medical records to determine what condition was accepted,[1] we disagree that that standard applies under the facts of this case.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Piwowar*, 305 Or at 501. In *Piwowar*, the carrier accepted a claim for a "sore back." After claim closure, subsequent medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. *Id.* at 497. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." *Id.* at 501. The Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, its denial of the preexisting condition constituted an impermissible "back-up" denial. *Id.* at 501-02.

Subsequently, the Court of Appeals applied *Piwowar* in *Emmert v. City of Klamath Falls*, 135 Or App 209 (1995). In *Emmert*, the claimant argued that because the carrier had previously accepted his claim for "severe chest pains," the carrier was precluded from subsequently denying the coronary artery disease that had been the cause of the chest pains. Reasoning that the notice of acceptance had not specified a particular condition, the court concluded that the acceptance must be read as constituting an acceptance of the claim as filed, which was for severe chest pain. Because we did not determine what caused claimant's chest pain, the court remanded for reconsideration.

On remand, we determined that the claimant's chest pain was caused, in part, by his underlying coronary artery disease. *John Q. Emmert*, 47 Van Natta 2068 (1995). Therefore, we concluded that, pursuant to *Piwowar*, the carrier had accepted the claim for coronary artery disease. Accordingly, we set aside the carrier's denial of that condition.

Here, on July 28, 1987, claimant initially injured his low back. On August 4, 1987, claimant submitted a claim for a "hurt back." (Ex. 1). In its October 14, 1987 acceptance of this claim, the insurer did not identify the condition it was accepting. (Ex. 10). Instead, it indicated only that the injury was accepted as "disabling" and assigned claim number 604-156164. (Ex. 10). Subsequently, on January 26, 1988, and March 30, 1988, claimant sustained new low back injuries in separate work incidents for which he submitted new claims for "back strain" and "pulled mussels [sic]," respectively. (Exs. 13, 15). Instead of processing these claims as new injuries, the insurer accepted the claims as part of the initial claim, marking the claims "duplicate 801 [form,] added to [claim number 604-] 156164." (*Id.*).

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[1] *Timothy Hasty*, 46 Van Natta 1209 (1994); *Cecilia A. Wahl*, 44 Van Natta 2505 (1992).

Pursuant to *Emmert*, we find that the insurer's acceptance must be read as constituting an acceptance of the claim as filed. Thus, in the case of the August 4, 1987 injury claim, the insurer accepted a claim for a "hurt back." Furthermore, like the ALJ, we find that the insurer's action in "adding" the new 1988 injury claims to the earlier accepted injury claim brings those claims within the carrier's earlier acceptance of a "hurt back." Thus, the insurer accepted whatever condition was causing claimant's "hurt back." As the ALJ found, the medical evidence establishes that claimant's "hurt back" was caused by the L4-5 disc herniation condition and, after the 1988 injuries, it was caused by his L5-S1 spondylolisthesis condition.

Citing *Barbara Simmons*, 46 Van Natta 1428 (1994), the insurer argues that *Piwowar* does not apply because "hurt back" is a description of the injury rather than a claim for back symptoms. We find *Simmons* distinguishable. In *Simmons*, the claimant argued that her claim was compensable under *Piwowar*. Specifically, the claimant relied on the language describing her injury in box 46 of the 801 claim form to argue that the carrier accepted a "hurt back," which the claimant argued was a symptom of a degenerative condition. We disagreed. Instead, we found that the language upon which the claimant relied was a description of how the injury occurred, not a claim for symptoms.

In contrast, here, claimant made a claim for a "hurt back." In this regard, in response to line 16 of the 801 form that requested the "[n]ature of injury of disease," claimant listed "hurt back." (Ex. 1). The descriptions of the injury that caused the "hurt back" were written on lines 17 and 46 of the 801 form. Thus, we find that, by accepting claimant's claim for "hurt back," the insurer accepted the cause of the "hurt back." *See Joann M. Deal*, 40 Van Natta 1870 (1988), *aff'd Liberty Northwest Ins. Corp. v. Deal*, 97 Or App 589 (1989) (the claimant made a claim for "hurt back" that the carrier accepted; the cause of the "hurt back" was lumbar spondylosis and spondylolisthesis of L5-S1; relying on *Piwowar*, the Board determined that, by accepting "hurt back," the carrier accepted the lumbar spondylosis and spondylolisthesis of L5-S1, which were the cause of the "hurt back"); *see also Norval W. Park*, 47 Van Natta 2085 (1992) (by not including an adequate degree of specificity in its acceptance, insurer accepted all the causes of the claimant's back symptoms, including spondylolisthesis condition).

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

ORDER

The ALJ's order dated June 11, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, payable by the insurer directly to claimant's attorney.

December 7, 1998 Cite as 50 Van Natta 2291 (1998)

In the Matter of the Compensation of
ANA GALVEZ-ALEMAN, Claimant
WCB Case No. 98-00440
ORDER OF ABATEMENT
Lundeen, et al, Defense Attorneys

On November 6, 1998, we affirmed an Administrative Law Judge's (ALJ's) order that dismissed claimant's request for hearing. Stating that she disagrees with our decision and has recently retained an attorney, claimant seeks "another opportunity to present my case."[1]

In order to further consider this matter, we withdraw our November 6, 1998 order. Before proceeding with our reconsideration, we grant each of the parties an opportunity to submit their respective written positions regarding the issues addressed in our November 6, 1998 order and arising from claimant's request "that my case be re-open[ed]." Those written responses must be filed in accordance with the following supplemental briefing schedule.

[1] Because it is unclear whether claimant mailed a copy of her request to the insurer, a copy of the request has been included with the insurer's copy of this order.

Claimant's opening brief must be filed within 21 days from the date of this order. The insurer's response must be filed within 21 days from the date of mailing of claimant's brief. Claimant's reply must be filed within 14 days from the date of mailing of the insurer's brief. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANK M. DIONNE, Claimant
WCB Case No. 98-0030M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney
Lundeen, et al, Defense Attorneys

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable low back injury. Claimant's aggravation rights expired on September 25, 1994. The insurer conceded that claimant remained in the work force, but recommended that the Board deny reopening claimant's claim on the grounds that: (1) the current condition does not require surgery or inpatient hospitalization; (2) the insurer is not responsible for claimant's current condition; and (3) surgery or hospitalization is not reasonable and necessary for the compensable injury. In addition, the insurer denied the compensability of claimant's current low back condition, degenerative disc disease at L4-5 and L5-S1, and anterolisthesis at L5-S1.

Claimant requested a hearing regarding the insurer's denial. (WCB Case No. 98-00857). On March 24, 1998, the Board postponed action on the own motion matter pending resolution of the litigation regarding the compensability issue. On June 11, 1998, Administrative Law Judge (ALJ) Livesley issued an order that set aside the insurer's January 20, 1998 denial, as amended March 24, 1998. The insurer requested Board review of ALJ Livesley's order and, by an order issued on today's date, the Board affirmed ALJ Livesley's order. *Frank M. Dionne*, 50 Van Natta 2290 (1998). Because the compensability issue has been resolved, we proceed with our consideration of the own motion matter.[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.*

Based on the outcome of the above litigation, we are persuaded that claimant's compensable low back injury has worsened. Furthermore, this worsening requires surgery, as evidenced by Dr. Hill's December 3, 1997 request for authorization to perform a lumbar fusion at L4-5 and L5-S1. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he 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.

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[1] We note that, although the insurer checked the boxes on the Own Motion Recommendation form indicating that it contended that it was not responsible for claimant's current condition and the surgery or hospitalization was not reasonable and necessary for the compensable injury, the insurer has not pursued either of these contentions. In this regard, no issue regarding responsibility was raised in the hearing that decided the compensability issue. In addition, there is no indication that the insurer formally contested the reasonableness and necessity of the proposed lumbar surgery. Thus, we conclude that the insurer's initial challenges regarding responsibility for claimant's current condition and reasonableness and necessity of the proposed surgery have been withdrawn.

In the Matter of the Compensation of
FRED L. DOBBS, Claimant
WCB Case Nos. 97-09540, 97-09535, 97-07489 & 97-02870
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys
Snarskis, Yager, et al, Defense Attorneys
Mannix, Nielsen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation, on behalf of Sherman Brothers (SAIF/Sherman), requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its compensability and responsibility denials of claimant's injury claim for a low back condition; (2) upheld the responsibility denials of the same condition from Industrial Indemnity, on behalf of Kwik Kafe of Oregon (Industrial Indemnity), SAIF, on behalf of Jerry & Jean Trucking, Inc. (SAIF/Jerry & Jean), and Liberty Northwest Insurance Corporation, on behalf of Sherman Brothers (Liberty/Sherman); and (3) awarded claimant's attorney an assessed fee of $4,000. On review, the issues are compensability, 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 changes. In the second paragraph on page 2, we change the third sentence to read: "He was treated by Dr. Miller and a lumbar myelogram indicated claimant had a herniated disc at the right at L5-S1. (Exs. C, D)." In the sixth paragraph on page 5, we change the second sentence to read: "He opined that the 'injury did not cause or worsen his pre-existing condition, but it probably did cause it to become symptomatic and aggravated his symptoms.' (Ex. 46-2)."

CONCLUSIONS OF LAW AND OPINION

Claimant, age 52 at hearing, has had several low back injuries and surgeries. He injured his low back in May 1978 while working for Industrial Indemnity's insured. (Ex. B). On July 26, 1978, Dr. Miller, who had performed two earlier back surgeries, performed a lumbar laminectomy with removal of an L5-S1 disc on the right. (Ex. E). The claim was closed with a 15 percent unscheduled permanent disability award on December 13, 1978. (Ex. I). Claimant had another surgery in June 1980 and Dr. Miller performed a lumbar laminectomy at L4-5 on the left. (Ex. O). On July 21, 1981, the claim was again closed with an additional award of 10 percent unscheduled permanent disability for the low back. (Ex. 3D).

While working for Jerry & Jean Trucking, Inc. (insured by SAIF) on July 10, 1983, claimant sustained another back injury. (Ex. 5). SAIF/Jerry & Jean accepted the claim, which was closed on February 15, 1984 with a 15 percent unscheduled permanent disability award for the low back. (Exs. 6, 15).

Claimant began working for Sherman Brothers in April 1984. (Tr. 17). At that time, Sherman Brothers was insured by Liberty Northwest. On February 2, 1987, he sustained a back and shoulder injury at work. (Ex. 17D). He was diagnosed with a low back strain. (Exs. 17F, 17G, 17H). The claim was closed on April 6, 1987 without an award of permanent disability. (Ex. 17HH).

On September 9, 1994, claimant sustained a low back injury while working for Sherman Brothers. (Ex. 17I). At that time, Sherman was insured by SAIF, who accepted a a nondisabling lumbosacral/cervical strain. (Ex. 17K).

On November 12, 1996, claimant injured his low back while removing a 125-pound tarp and attempting to place it in a box on the side of a trailer. (Tr. 18). Claimant's right leg went numb and he had extreme lower back pain. (Tr. 19). On February 7, 1997, SAIF/Sherman accepted a claim for a nondisabling lumbar strain. (Ex. 24).

On January 18, 1997, Drs. Ballard and Weller examined claimant on behalf of SAIF and reported that claimant's lumbar strain from the November 1996 injury had resolved. (Ex. 23-8). They concluded that "well more than 50 percent" of his current treatment was caused by his prior or preexisting low back injuries and surgeries. (*Id.*)

On April 3, 1997, SAIF/Sherman denied compensability of claimant's current low back condition. (Ex. 35). The denial stated, in part:

> "Your accepted lumbar strain combined with one or more pre-existing condition(s). However, on March 17, 1997, your lumbar strain has ceased to be the major cause of the treatment and disability of the combined condition." (*Id.*)

SAIF/Sherman denied responsibility on May 23, 1997. (Ex. 39).

Liberty/Sherman and Industrial Indemnity denied responsibility of claimant's current condition. (Exs. 42, 45). SAIF/Jerry & Jean issued denials on November 21, 1997 and December 15, 1997. (Exs. 48A, 52).

At hearing, the ALJ relied on *Daral T. Morrow*, 49 Van Natta 1979, *on recon* 49 Van Natta 2105 (1997), and concluded that SAIF/Sherman was responsible for claimant's current low back condition.

SAIF/Sherman argues that the ALJ incorrectly decided that it had accepted a combined condition in this claim and erred in holding that ORS 656.308(1) barred SAIF/Sherman from denying claimant's current low back condition. SAIF/Sherman argues that the *Morrow* case is distinguishable.

In *Morrow*, the claimant had a compensable claim with SAIF 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 had sustained a "new compensable injury" to warrant shifting responsibility to a later carrier, nor did the employer contend that the claimant's current need for treatment was not compensably related to his employment generally. 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.

We have applied *Morrow* in *Thomas E. Mooney*, 50 Van Natta 1515 (1998), and *David E. McAtee*, 50 Van Natta 649 (1998). On the other hand, in *David E. Stutzman*, 50 Van Natta 776, 777 n.1 (1998), we distinguished the *Morrow* case. In *Stutzman*, we concluded that the claimant's current condition did not involve the "same condition" that was processed as part of the 1969 and 1986 compensable injuries. Moreover, we found that the carrier for the 1986 injury had never assumed responsibility, either by litigation or by application of ORS 656.308, for any part of the claimant's 1969 injury. Because ORS 656.308 was inapplicable, we found that *Stutzman* was distinguishable from *Morrow*.

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

Thus, our initial inquiry is to determine whether the current condition claim is for a condition that was previously accepted. *See Conner v. B & S Logging*, 153 Or App 354, 358 n.2 (1998). We examine the medical evidence to determine whether claimant's current condition is the "same condition" as any of his accepted conditions. We begin by examining claimant's two most recent accepted claims from SAIF/Sherman. After claimant's November 1996 injury, SAIF/Sherman accepted a claim for a nondisabling lumbar strain. (Ex. 24). As a result of claimant's September 1994 low back injury, SAIF/Sherman accepted a nondisabling claim for a lumbosacral/cervical strain. (Ex. 17K).

Regarding claimant's current low back condition, Dr. Lewis, claimant's treating physician, testified that his main problem "has to do with degeneration of his spine, which is long standing in nature, with some stenosis, tightness-type problems secondary to the degeneration." (Ex. 53-6). He felt that claimant had sustained a strain as a result of the November 1996 injury, which combined with his preexisting condition. (Ex. 53-6, -7). However, Dr. Lewis believed that claimant's preexisting condition was the major cause of his current condition. (Ex. 53-9, -12).

Dr. Lewis' opinion is consistent with the opinion of Drs. Ballard and Weller, who concluded that claimant's preexisting low back injuries and surgeries were the major cause of claimant's current low back condition. (Ex. 23-8). In a later report, Dr. Ballard said that claimant's current need for treatment was due in major part to this preexisting condition. (Ex. 46-3). He explained that claimant had preexisting spinal stenosis and foraminal narrowing.

None of the medical opinions indicate that claimant continues to suffer from a lumbar strain. Rather, the medical reports indicate that claimant's current low back condition includes degeneration of the lumbar spine and spinal stenosis. SAIF/Sherman's acceptances were for a nondisabling lumbar strain and a nondisabling lumbosacral/cervical strain. (Exs. 17K, 24). Because SAIF/Sherman's acceptances did not include degeneration of the lumbar spine and spinal stenosis, we conclude that they did not involve the "same condition" as claimant's current low back condition. Therefore, ORS 656.308(1) does not apply to the SAIF/Sherman's claims.

We examine the other accepted claims to determine if claimant's current condition was previously accepted. On February 2, 1987, claimant injured his back and shoulder while working for Sherman Brothers. (Ex. 17C, 17D). The record indicates that the claim was accepted by Liberty/Sherman, but there is no specific acceptance in the file. (Exs. 17D, 17HH). The scope of acceptance is a factual determination. *SAIF v. Tull*, 113 Or App 449 (1992). When the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. *Mary Marrs-Johnston*, 49 Van Natta 1757 (1997); *Timothy Hasty*, 46 Van Natta 1209 (1994).

Here, we find that the contemporaneous medical documents establish that the back condition Liberty/Sherman accepted was a low back strain. A chart note on February 10, 1987 diagnosed a low back strain. (Ex. 17B). A March 8, 1997 chart note referred to a "[l]ow back strain, essentially resolved" and indicated that claimant was back to normal work activities without significant problems. (Ex. 17H). The claim was closed on April 6, 1987 without an award of permanent disability. (Ex. 17HH). Based on our determination that Liberty/Sherman accepted a low back strain, and our conclusion that its acceptance did not include degeneration of the lumbar spine and spinal stenosis, we conclude that the Liberty/Sherman claim did not involve the "same condition" as claimant's current low back condition. Therefore, ORS 656.308(1) does not apply to the Liberty/Sherman claim. Our conclusion is supported by Dr. Lewis' testimony that the 1987 injury "had very little, if any, probably nothing to do with his current situation." (Ex. 53-19).

Claimant injured his back on July 10, 1983 while working for Jerry & Jean Trucking. (Ex. 5). On review, SAIF/Jerry & Jean contends that it accepted "sciatic nerve inflammation" as a result of the July 1983 injury. However, the Notice of Claim Acceptance did not specify that a particular condition had been accepted. (Ex. 6). Although the acceptance form referred to the code "400 498," the code did not limit the acceptance. Therefore, the notice of acceptance must be read as constituting an acceptance of the claim as filed. *See Emmert v. City of Klamath Falls*, 135 Or App 209, 212 (1995) (carrier accepted the condition(s) that caused "severe chest pains").

As we discussed earlier, when the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Georgia Pacific v.*

Piwowar, 305 Or 494 (1988). In *Piwowar*, the carrier accepted a claim for a "sore back." Subsequent medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. *Id.* at 497. The Supreme Court explained that a carrier is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." *Id.* at 501. The Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, it could not properly deny compensability of the ankylosing spondylitis. *Id.* at 501-02.

Here, claimant signed an "827" form for the July 10, 1983 injury, stating that the "chain binder kicked back throwing me off the load onto ground." (Ex. 5). Dr. Cutsforth signed the form on July 15, 1983, referring to an "attached dictation" for the diagnosis. (*Id.*) The "827" form in the record does not include an attachment. The only "801" form in file for the July 10, 1983 injury is a "dummy" form not signed by claimant, which was apparently prepared by SAIF. (Ex. 5A). The record includes a chart note dated July 13, 1983, apparently from Dr. Cutsforth, which refers to: "OTJ injury with sciatic notch pain. One wonders whether this represents a direct injury to the sciatic nerve versus some flare-up of his previous lumbar surgical area." (Ex. 4). The July 13, 1983 chart note described claimant's three previous lumbar surgeries. (*Id.*)

On July 28, 1983, Dr. Cutsforth reported that claimant's findings on July 13, 1983 suggested "sciatic nerve inflammation possibly secondary to a new neurological injury or a flare-up of his previous lumbar disc surgical area." (Ex. 7). A chart note on August 10, 1983 diagnosed sciatic nerve root compression. (Ex. 8). On September 1, 1983, Dr. Cutsworth reported to SAIF that claimant had preexisting permanent impairment as a result of his three previous lumbar surgeries. (Ex. 9-1). Although he felt that claimant's July 1983 injury had occurred unrelated to the preexisting impairment, Dr. Cutsworth said that the injury probably caused a more serious low back problem because of the preexisting condition. (*Id.*) He felt that the severity of the trauma would be enough to cause a ruptured disc or vertebral injury and was more likely to result in one of those conditions because of claimant's anatomically weaker back. (Ex. 9-2).

Dr. Miller examined claimant on September 6, 1983 and recommended conservative treatment. (Ex. 10). On October 25, 1983, Dr. Miller's impression was recurrent herniated disc, L5-S1 on the left. (Ex. 12-2). A later report indicated that Dr. Miller had recommended doing a myelogram and had discussed the possibility of surgery, but claimant did not want further surgery and did not have the myelogram. (Ex. 14-1).

On January 14, 1984, claimant was examined by Drs. Wilson and Logan regarding the July 1983 injury. (Ex. 14). Claimant's chief complaints were low back and left leg pain. (Ex. 14-2). They diagnosed "[s]tatus postop lumbar laminectomy at L5-S1 times three with residual lower back and leg symptoms" and disc space narrowing at L4-5 and L5-S1. (Ex. 14-3). Drs. Wilson and Logan reported that the July 1983 x-rays showed narrowing of L5-S1 and slight narrowing of L4-5. (*Id.*) Dr. Miller concurred with their report. (Ex. 16). The claim was closed on February 17, 1984 with an award of 15 percent permanent disability for a low back condition. (Ex. 15).

Although SAIF/Jerry & Jean asserts that it accepted "sciatic nerve inflammation" as a result of the July 1983 injury, we find that it did not issue a specific acceptance. Because the Notice of Claim Acceptance did not specify that a particular condition was accepted, it must be read as constituting an acceptance of the claim as filed. Claimant filed a claim for the July 10, 1983, stating that "the chain binder kicked back throwing me off the load onto ground." (Ex. 5). The foregoing medical reports indicate that claimant had been diagnosed with several conditions, including sciatic nerve root compression, a recurrent herniated disc at L5-S1, "[s]tatus postop lumbar laminectomy at L5-S1 times three with residual lower back and leg symptoms" and disc space narrowing at L4-5 and L5-S1. (Exs. 8, 12, 14). By not including an adequate degree of specificity in its acceptance, SAIF/Jerry & Jean accepted all the causes of claimant's back symptoms, including the disc space narrowing at L4-5 and L5-S1 and residual lower back and leg symptoms from his three previous surgeries. *See Georgia Pacific v. Piwowar*, 305 Or at 501-02.

We find that claimant's current low back condition, which includes degeneration of the lumbar spine and spinal stenosis, is the same as the conditions accepted by SAIF/Jerry & Jean. Under ORS 656.308(1), SAIF/Jerry & Jean remains responsible for future compensable medical services and disability

relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition."[1] We find no evidence that claimant sustained a "new compensable injury" that involved the same condition. As we discussed earlier, SAIF/Sherman's acceptances of a lumbar strain and a lumbosacral/cervical strain did not include degeneration of the lumbar spine and spinal stenosis and, therefore, did not involve the "same condition" as claimant's current low back condition. Similarly, Liberty/Sherman's acceptance of a low back strain did not include degeneration of the lumbar spine. Therefore, we conclude that SAIF/Jerry & Jean remains responsible for claimant's current low back condition. Consequently, we set aside SAIF/Jerry & Jean's denials and uphold SAIF/Sherman's denials. (Exs. 48A, 52).

Attorney Fees

At hearing, only SAIF/Sherman disputed compensability.[2] The ALJ set aside SAIF/Sherman's compensability and responsibility denials and awarded claimant's attorney an assessed fee of $4,000. As a result of this order, we are upholding SAIF/Sherman's responsibility denial. (Ex. 39). In its April 3, 1997 denial, SAIF/Sherman denied compensability of claimant's current low back condition on the basis that his lumbar strain had ceased to be the major cause of the treatment and disability of the combined condition. (Ex. 35). In light of our conclusion that SAIF/Jerry & Jean is responsible for claimant's current low back condition pursuant to ORS 656.308(1), we uphold SAIF/Sherman's compensability denial. Therefore, claimant is not entitled to an attorney fee under ORS 656.386(1).

Nevertheless, claimant is entitled to a carrier-paid attorney fee award under ORS 656.308(2)(d) because his attorney "actively and meaningfully participated" in the responsibility dispute at hearing and on Board review. Claimant filed hearing requests contesting SAIF/Jerry & Jean's responsibility denials and has successfully prevailed over those denials. Claimant's attorney contended at hearing and on review that SAIF/Sherman was responsible for his current low back condition. Although claimant's argument was not successful, his attorney's participation was "active and meaningful" and, by virtue of his successful hearing requests, claimant has finally prevailed against SAIF/Jerry & Jean's responsibility denials. *See Douglas H. Brooks*, 48 Van Natta 736, 739 (1996); *Paul R. Huddleston*, 48 Van Natta 4, *on recon* 48 Van Natta 203 (1996).

ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances. In determining a reasonable attorney fee for claimant's participation in this responsibility dispute, we have considered that claimant's arguments as to the responsible carrier were unsuccessful. *See International Paper Co. v. Riggs*, 114 Or App 203, 207 (1992) (the claimant's pursuit of unsuccessful arguments may be taken into account in determining what fee is reasonable); *Paul R. Huddleston*, 48 Van Natta at 10.

At hearing, claimant's attorney indicated that he would be requesting an extraordinary attorney fee award under ORS 656.308(2)(d). (Tr. 10-11). However, in closing argument claimant merely requested an assessed fee against SAIF/Sherman as the only carrier denying compensability. In his statement of services, claimant's attorney did not indicate he was requesting an extraordinary fee. In any event, even if we assume that claimant sought an extraordinary attorney fee, we do not find extraordinary circumstances warranting an increased award under ORS 656.308(2)(d).

Four carriers were joined at the hearing. The hearing in this case lasted one hour, 20 minutes. Claimant testified on his own behalf. Ninety-six exhibits were received into evidence, nine of which were generated or submitted by claimant's counsel. There was one deposition, which lasted 55 minutes. Although the value of the claim was above average proportions, the complexity of the issue or value of the benefits do not differ appreciably from those in most cases litigated before this forum. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous

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[1] We note that SAIF/Jerry & Jean did not contest the compensability of claimant's current condition. Rather, it denied its responsibility for the condition on the basis that it was the result of other claims or the result of previous surgeries. Consequently, ORS 656.262(6)(c) and (7)(b) do not apply. As we have rejected its "responsibility" contention, it follows that SAIF/Jerry & Jean is responsible for claimant's current low back condition.

[2] Although claimant initially contended that SAIF/Jerry & Jean had issued a compensability denial and, therefore, he was entitled to an attorney fee (Tr. 8-9, Ex. 48A), claimant's attorney subsequently withdrew the issue of an attorney fee under ORS 656.386(1) against SAIF/Jerry & Jean.

issues or defenses were presented. There was a significant risk that claimant's counsel's efforts might go uncompensated. We note that, although claimant's attorney submitted a statement of services at hearing, he did not indicate how much time was devoted to this case. On review, claimant's counsel submitted a 4-page respondent's brief.

Under similar facts, we have found that there were no "extraordinary circumstances" under ORS 656.308(2)(d). For example, in *Bill D. Coleman*, 48 Van Natta 2154 (1996), the hearing lasted three hours and had two witnesses, there were 186 exhibits, some of which were procured by claimant's counsel, and there was a 53-page deposition. The claimant filed a 15-page respondent's brief. Likewise, in *Terry L. Vanyi*, 50 Van Natta 1016 (1998), the hearing lasted one hour and fifteen minutes, there were 53 exhibits, 47 of which submitted by the claimant's attorney, and the claimant submitted a three-page respondent's brief on review.

In this case, after considering the aforementioned factors, we do not find extraordinary circumstances to warrant an attorney fee in excess of the statutory $1,000 limit. In determining a reasonable attorney fee for claimant's participation in this responsibility dispute, we have considered that claimant's arguments as to the responsible carrier were unsuccessful.[3] Consequently, claimant's counsel is awarded a $1,000 attorney fee for services at hearing and on review, payable by SAIF/Jerry & Jean. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997); *Tammy Locke*, 48 Van Natta 250 (1996) (concluding that the legislature intended, in cases in which a claimant finally prevails against a responsibility denial, to authorize a maximum cumulative attorney fee of $1,000 for services at all levels of litigation, except in cases involving extraordinary circumstances).

ORDER

The ALJ's order dated June 5, 1998 is reversed in part, affirmed in part and modified in part. That portion of the ALJ's order that set aside SAIF/Sherman's compensability and responsibility denials is reversed. SAIF/Sherman's compensability and responsibility denials are reinstated and upheld. The portion of the ALJ's order that upheld SAIF/Jerry & Jean's denials of responsibility is reversed. SAIF/Jerry & Jean's denials of claimant's low back condition are set aside, and the claim is remanded to SAIF/Jerry & Jean for further processing according to law. In lieu of the ALJ's $4,000 attorney fee award, claimant's attorney is awarded a $1,000 assessed fee for his services at hearing and on review regarding SAIF/Jerry & Jean's responsibility denial, to be paid by SAIF/Jerry & Jean. The remainder of the ALJ's order is affirmed.

[3] In claimant's closing argument, he contended that SAIF/Sherman was responsible or alternatively, Industrial Indemnity was responsible. On review, claimant's counsel submitted a 4-page respondent's brief, contending that the ALJ's responsibility determination should be affirmed. We acknowledge that claimant's counsel expended a significant amount of effort in trying to prove that SAIF/Sherman is responsible for claimant's current low back condition. Notwithstanding such efforts, we have determined that responsibility for claimant's condition rests with SAIF/Jerry & Jean.

In the Matter of the Compensation of
ROBERT NICKLE, Claimant
Own Motion No. 97-0380M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 9, 1998 Own Motion Order Reviewing Carrier Closure on Reconsideration, in which we adhered to and republished our September 22, 1998 order in its entirety. As it appears that claimant did not forward a copy of his December 2, 1998 request to the SAIF Corporation, we enclose a copy for SAIF.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The 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
JOHN KUNSMAN, Claimant
WCB Case No. 98-01358
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's injury claim for toxic fume exposure. On review, the issues are evidence and compensability. We reverse.

FINDINGS OF FACT

Claimant began working as a circuit board inspector and solderer in November 1997. (Tr. 16-17). On December 30, 1997, he experienced watering eyes and dizziness at work for the first time. (Tr. 17-18). Claimant explained that, on December 30, he did not have a fan available to keep the solder fumes away. (Tr. 18). He advised his supervisor of his symptoms and he was taken to the emergency room. (Tr. 22). In the course of treatment, claimant discovered that he had left leg cellulitis. (Tr. 23, 24).

Claimant was treated by Dr. Zimmerman on December 30, 1997. (Exs. 5, 6). Dr. Zimmerman reported that claimant had been soldering at work when his eyes began to water and he started getting dizzy. (Ex. 5-1). Dr. Zimmerman found that claimant had an erythema from his left ankle extending to the mid left leg. (Ex. 5-2). Dr. Zimmerman diagnosed left leg cellulitis, fever and bandemia. (*Id.*) In an addendum report the following day, Dr. Zimmerman indicated he had consulted Dr. Atwal about the case and the working diagnosis was "fever secondary to cellulitis of the leg." (Ex. 6-1). Claimant was treated with intravenous antibiotics and antipyretics. (*Id.*)

Dr. Zimmerman signed an "827" form on December 30, 1997, listing claimant's symptoms as dizziness, eye irritation and fever and showing the diagnosis as cellulitis left leg. (Ex. 2).

Claimant sought follow-up treatment from Dr. Swanson on January 7, 1998. (Ex. 7). Dr. Swanson reported that claimant had been treated for "dizziness (¢ breathing solder fumes at work') and found to have a cellulitis of left LE." (Ex. 7-1). He said that claimant's dizziness had "completely resolved" and the cellulitis was "resolving." (*Id.*) Dr. Swanson commented that claimant should "[k]eep using the fan at work to blow the solder resin/smoke away from you." (Ex. 7-2)

The insurer denied the claim on the basis that claimant's work exposure was neither the major nor material contributing cause of his conditions. (Ex. 8).

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the insurer's attorney objected to the admission of Exhibit A, which consisted of a four-page "Material Safety Data Sheet" (MSDS) for organic flux. The insurer's attorney argued that Exhibit A did not have any probative value because the issue in the case was a medical question. (Tr. 14). Claimant's attorney contended that it was a public record, an OSHA document, which was properly admissible. (*Id.*) Claimant's attorney explained:

> "I'm offering it as evidence as material contributing cause applying here, so I don't think there needs to be medical evidence that, in fact, he became dizzy at work. However, I would like to offer it as proof that, in fact, the solder he was using has one of the acute effects of causing dizziness." (Tr. 14, 15).

The ALJ overruled the insurer's objection and accepted the argument "as going to weight." (Tr. 15).

Finding that the MSDS for the solder claimant had used warned against inadequate ventilation, the ALJ concluded that claimant developed the symptoms the MSDS warned of in such a circumstance. The ALJ determined that the sole reason that claimant sought medical treatment on December 30, 1997 was his exposure to the soldering fumes.

The insurer asserts that the issue is not whether the MSDS was admissible *per se*.[1] Rather, the insurer contends that the ALJ erred by admitting the MSDS for the purpose of proving medical causation. The insurer argues that the ALJ permitted the MSDS information to substitute for a medical opinion.

For the reasons that follow, we find that this case requires expert medical evidence to prove causation. Therefore, we agree with the insurer that the MSDS cannot, by itself, establish a causal connection between claimant's work exposure and his symptoms.

Compensability

The ALJ found that expert medical evidence was not required to establish compensability. The ALJ reasoned that there was no evidence that claimant's cellulitis combined with the effects of his toxic exposure, or that the symptoms of the two separate conditions were inseparable or subject to confusion.

The insurer contends that expert evidence was required to prove causation. The insurer asserts that claimant's cellulitis and fever offered an alternative, non-work-related explanation for his symptoms of dizziness. The insurer acknowledges that claimant reported his dizziness promptly, but asserts that he delayed at least a week before reporting his suspicions of toxic exposure. The insurer further contends that the ALJ did not really analyze this as a simple case because she permitted the MSDS information concerning exposure symptoms to substitute for a medical opinion that such exposure was the probable cause of claimant's symptoms.

Medical evidence is not always required to establish causation. The relevant factors for determining whether expert evidence concerning causation is required are: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker previously was free from disability of the kind involved; and (5) whether there was expert evidence that the alleged precipitating event could not have been the cause of the injury. *Barnett v. SAIF*, 122 Or App 279 (1993).

In *Uris v. Compensation Department*, 247 Or 420 (1967), the plaintiff felt a sharp pain in his back after reaching out to prevent a truckload of books from toppling over. He had experienced no trouble with his back since he was 13 or 14 years of age. He reported the incident to his employer and went immediately to a doctor, who found a back injury. He was later diagnosed with a chronic lumbosacral (low back) strain. The court reasoned that expert medical evidence was not necessary:

> "There is nothing very complicated about such an injury and its cause. Neither was it beyond the competence of a jury of laymen to infer from the entire testimony that the sudden movement to which the plaintiff testified caused the pain he felt at that moment and the condition from which he suffered thereafter." *Id.* at 427.

Here, the claim is for toxic fume exposure. Unlike *Uris*, we find that this condition is complicated and the causation of toxic fume exposure is "beyond the competence" of lay people. We acknowledge that claimant's symptoms of dizziness and eye irritation appeared shortly after soldering at work with inadequate ventilation and that he promptly sought medical treatment. Nevertheless, the medical reports on December 30 and 31, 1997 did not associate claimant's symptoms with toxic fume exposure. Rather, he was diagnosed with left leg cellulitis, fever and bandemia.[2] Contrary to claimant's assertion that there is no expert opinion that his symptoms were caused by cellulitis, Dr. Zimmerman's report indicates that his eye irritation and dizziness were associated with cellulitis and fever.

Claimant was treated by Dr. Zimmerman on December 30, 1997. (Exs. 5, 6). Dr. Zimmerman reported that claimant had been soldering at work when his eyes began to water and he started getting dizzy. (Ex. 5-1). Dr. Zimmerman reported that claimant had an erythema from his left ankle extending to the mid left leg. (Ex. 5-2). Dr. Zimmerman diagnosed left leg cellulitis, fever and bandemia. (*Id.*) In an addendum the following day, Dr. Zimmerman indicated he had consulted Dr. Atwal about the case and the working diagnosis was "fever secondary to cellulitis of the leg." (Ex. 6-1). Claimant was treated with intravenous antibiotics and antipyretics. (*Id.*)

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[1] Because the insurer does not object to the admissibility of the MSDS, we need not address claimant's argument that the Board should take "judicial notice" of the MSDS.

[2] We agree with the insurer that the record contains no explanation of "bandemia."

Dr. Zimmerman signed an "827" form on December 30, 1997, listing claimant's symptoms as dizziness, eye irritation and fever and showing the diagnosis as cellulitis left leg. (Ex. 2).

Although Dr. Zimmerman noted that claimant's eyes began to water and he started getting dizzy while soldering at work, his diagnoses do not refer to toxic fume exposure. Rather, he diagnosed left leg cellulitis, fever and bandemia. His reports did not indicate that those diagnoses were related to claimant's soldering activities. Under these circumstances, we are not prepared to infer that soldering at work caused claimant's symptoms. We disagree with claimant's assertion that his injury and its cause are not complicated.

Claimant sought follow-up treatment from Dr. Swanson on January 7, 1998. (Ex. 7). Dr. Swanson reported that claimant had been treated for "dizziness (¢ breathing solder fumes at work') and found to have a cellulitis of left LE." (Ex. 7-1). He said that claimant's dizziness had "completely resolved" and the cellulitis was "resolving." (*Id.*) Dr. Swanson commented that claimant should "[k]eep using the fan at work to blow the solder resin/smoke away from you." (Ex. 7-2).

Dr. Swanson's report indicates that claimant's dizziness may have been caused by breathing solder fumes at work. (Ex. 7). On the other hand, in the "827" form, Dr. Zimmerman referred to claimant's dizziness, eye irritation and fever as symptoms of a "cellulitis left leg" diagnosis. (Ex. 2). Thus, there is evidence in the record that claimant's dizziness and eye irritation may have been caused by the cellulitis, not the solder fumes. Under these circumstances, we conclude that expert evidence is required to establish causation.

We find that the medical evidence is insufficient to establish compensability. As we discussed earlier, Dr. Swanson reported that claimant had been treated for "dizziness (¢ breathing solder fumes at work')" and he commented that claimant should use a fan at work to blow away the solder resin/smoke. (Ex. 7). Dr. Swanson's observations support only a possibility that the soldering at work caused claimant's dizziness and eye watering. This is insufficient to carry claimant's burden of proof. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). Furthermore, Dr. Swanson did not discuss or comment on the chemical makeup of solder or how it causes dizziness. Dr. Swanson did not explain whether or not claimant's cellulitis condition could have caused or contributed to the dizziness. In contrast, Dr. Zimmerman associated claimant's dizziness, eye irritation and fever symptoms with left leg cellulitis. We conclude that claimant has failed to prove the compensability of his toxic fume exposure.[3]

ORDER

The ALJ's order dated June 22, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[3] In light of our conclusion, we need not address the insurer's argument that claimant is not entitled to an attorney fee and that the attorney fee award was excessive.

In the Matter of the Compensation of
ANITA I. MITCHELL, Claimant
Own Motion No. 98-0065M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable contusion of coccyx and sacroiliac ligament strain. Claimant's aggravation rights expired on September 21, 1989. SAIF issued a denial of the compensability of claimant's current S1 dysfunction with exacerbation of chronic lumbosacral strain and muscle guarding on February 3, 1998. Claimant timely appealed that denial. (WCB Case No. 98-01105). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) no surgery or hospitalization has been requested; (2) it is not responsible for claimant's current condition; (3) surgery or

hospitalization is not reasonable and necessary for the compensable injury; and (4) claimant was not in the work force at the time of disability.

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

Here, claimant did appeal the February 3, 1998 denial; however, she withdrew her request for hearing. An Order of Dismissal issued on November 3, 1998. That order has not been appealed. Thus, the current S1 dysfunction with exacerbation of chronic lumbosacral strain and muscle guarding for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted claimant's current condition as compensable. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH A. MEYER, Claimant
WCB Case No. 97-08075
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Lane, Powell, 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) Menashe's order that: (1) awarded procedural temporary total disability (TTD) benefits commencing February 2, 1998; (2) awarded claimant a $1,500 assessed attorney fee for prevailing over the employer's "de facto" denial of claimant's left carpal tunnel syndrome (CTS); and (3) assessed a 25 percent penalty for the employer's allegedly unreasonable failure to provide discovery of payroll records. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty or attorney fee for the employer's allegedly unreasonable delay in accepting claimant's left and right CTS. In his brief on review, claimant also requests penalties for additional alleged discovery violations. On review, the issues are entitlement to procedural TTD, penalties and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

Claimant developed bilateral CTS while working as a "lumber grader" for the employer. On July 22, 1997, he filed a claim for right CTS. On July 23, 24, 25 and 28, claimant returned to work and was assigned to a modified job as a "spot grader." Claimant received his $13.97 at-injury wage for this modified work. On July 28, 1997, the employer fired claimant on the ground that he had violated its drug and alcohol policy by not taking a drug and alcohol test within twenty-four hours of his initial medical treatment for CTS. Thereafter, claimant continued to experience bilateral carpal tunnel symptoms and remained on TTD status. On October 29, 1997, the employer issued an acceptance of right CTS. On November 3, 1997, Dr. Brett performed a right carpal tunnel release and authorized further TTD.

Meanwhile, on September 23, 1997, claimant's attorney wrote the employer's claims adjuster requesting the following documents: claimant's personnel file; the ledger showing TTD payments made in this claim; all claims processing forms submitted to the Board in connection with this claim; and "[p]ayroll records or other documents from the employer for the twelve months prior to the date of this claim and for the time the claim has been pending." At the time of hearing, the employer had not responded to the request for the personnel file, TTD ledger and Form 1502. In a November 4, 1997 fax,

the claims adjuster asked claimant's attorney to "[p]lease advise specifically what you would like in the way of payroll records - time cards, copies of checks, stubs?" By return fax on the same day, claimant's attorney responded "time cards." On November 7, 1997, the employer provided claimant's attorney with copies of claimant's time cards. On January 12, 1998, claimant's attorney received additional documentation from the employer's counsel regarding claimant's payroll and rate of pay.

Sometime prior to January 9, 1998, the employer recalculated claimant's TTD rate to include overtime pay. Based on this recalculation, the employer paid claimant additional TTD, in the amount of $1,014.23, for the period July 28, 1997 through January 12, 1998. This additional TTD was paid on January 26, 1998.

Meanwhile, on November 1, 1997, claimant's attorney wrote the employer requesting that it amend its acceptance to include left CTS. The claims adjuster then sought medical verification that claimant had objective documentation of a left CTS due in major part to his work activity. When the employer did not respond to claimant's request for an amended acceptance within 30 days, claimant requested a hearing on December 5, 1997. The employer issued an amended acceptance of bilateral CTS on December 10, 1997.

Effective February 2, 1998, Dr. Brett released claimant to light duty work as a "grader trainer" after approving a position description for this job. According to the approved position description, the "grader trainer" job required claimant to "watch potential graders mark lumber [and] verbally correct any mistakes" from 6:00 to 2:30, five days per week. The position description also stated that the job did not require use of the upper extremities. By letter dated February 23, 1998, the employer informed claimant that it was terminating his TTD based on "Dr. Brett releasing you on February 2, 1998 to perform the job duties of 'grader trainer,' a job you were performing on July 28, 1997, at which time you were terminated by your employer for violation of a company policy." The employer then terminated claimant's TTD benefits as of February 2, 1998.

CONCLUSIONS OF LAW AND OPINION

Procedural Temporary Total Disability (TTD)

The employer challenges the ALJ's conclusion that it improperly terminated claimant's procedural TTD benefits. The employer contends it had the authority to terminate claimant's TTD under ORS 656.325(5)(b) and OAR 436-060-0030(6).

ORS 656.325(5)(b) provides in pertinent part:

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

The administrative rules implementing ORS 656.325(5)(b) are set forth at OAR 436-060-0030(6), which provides in pertinent part:

> "Pursuant to ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:
>
> "(a) The employer has a written policy of offering modified work to injured workers:
>
> "(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (2);

"(c) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and

"(d) The attending physician agrees the employment appears to be within the worker's capabilities."

Here, the ALJ reasoned that the record did not establish that the employer had the wage information required under OAR 436-060-0030(6)(b). Accordingly, the ALJ concluded that claimant's TTD was improperly terminated because it did not strictly comply with that rule. *See SAIF v. Robertson,* 120 Or App 1 (1993) (when a rule specifically and unambiguously requires the employer to follow a certain procedure, substantial compliance is not sufficient); *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986) (employer must strictly comply with the applicable administrative rule before it can unilaterally terminate TTD).

On review, the employer contends that the record establishes it had written documentation that claimant would have been paid at the rate of $13.97 an hour if he had returned to work as a "grader trainer". In the alternative, the employer argues that this wage information is not relevant in determining whether it properly terminated claimant's TTD, and is only required to support the calculation of temporary partial disability (TPD). In response, claimant relies on the ALJ's rationale and also contends that: the modified job Dr. Brett approved was not the actual modified job available in February 1998; the record does not establish that the employer had the requisite written documentation of hours; and the employer did not terminate claimant for "violation of work rules or other disciplinary reasons."

We first consider claimant's contention that the "grader trainer" position approved by Dr. Brett is not the actual job claimant would have performed had he returned to work in February 1998. The employer's February 23, 1998 letter describes the available "grader trainer" job as the same job claimant was performing when he was terminated in late July 1997. And, claimant's foreman has provided a description of claimant's assigned duties in late July 1997 that is consistent with the "grader trainer" duties approved by Dr. Brett. Claimant did testify that he also performed some of his regular "lumber grader" duties in late July 1997. But, we are not persuaded that the employer required, expected or even knew that claimant was performing this more strenuous work. On this record, we find that the "grader trainer" position approved by Dr. Brett is the position that would have been available to claimant in February 1998.

We further conclude that the employer did have the requisite written documentation of hours and wages when it terminated claimant's TTD. The "grader trainer" job description approved by Dr. Brett clearly states that the job required claimant to work from "6:00 to 2:30" five days per week. Furthermore, the employer's written payroll records document that claimant received his $13.97 at-injury wage when he performed the same job in late July 1997. There is no evidence that claimant would not have received the same $13.97 per hour wage had he returned to this position in February 1998. Consequently, we conclude that the record establishes that the employer had "written documentation of the hours available to work and the wages that would have been paid" within the meaning of OAR 436-060-0030(6)(b)[1].

Finally, we reject claimant's argument that the employer did not terminate claimant "for violation of work rules or other disciplinary reasons" within the meaning of ORS 656.325(5)(b). Specifically, claimant argues that discrimination and/or retaliation for pursuing rights and remedies under Oregon's Workers' Compensation Law motivated claimant's discharge, not violation of the employer's work rule. But the record indicates that the employer fired claimant because he did not take the drug test required under the employer's policy, not because he filed a workers' compensation claim or could not perform his regular job because of his compensable injury. To the extent the employer's action was unreasonable, unjustified, discriminatory or unlawful, these are not issues within the

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[1] We note that OAR 436-060-0030(6)(b) does not require the employer to present the wage and hour information to claimant. *Compare Eastman,* 79 Or App at 612 (carrier cannot terminate TTD for refusal of wage earning employment under *former* OAR 436-54-222(6) unless the employer has provided the injured worker with a written offer of employment stating the time, date, place, duration, and wage rate of the available job).

purview of workers' compensation law. *See Dawes v. Summers*, 118 Or App 15 (1993) (where the claimant was fired for non-claim related reasons and lost no wages because of her compensable injury, no temporary disability compensation was due following her termination); *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118 (1987) (where the claimant has not lost wages because of an inability to work as a result of his compensable injury, he is not entitled to temporary disability benefits; *Glenn E. Hall*, 48 Van Natta 1452 (1996) (claimant's remedy for unlawful or unjustified termination is civil action under ORS Chapter 659).

In summary, we reject the ALJ's finding that the employer did not have the requisite written documentation of wages. And we conclude that the employer otherwise strictly complied with the requirements of OAR 436-060-0030(6). Accordingly, we reverse the ALJ's award of procedural TTD commencing February 2, 1998.[2]

Assessed Attorney Fee

The employer challenges the ALJ's award of a $1,500 assessed attorney fee under ORS 656.386(1) for prevailing over its "de facto" denial of claimant's left CTS.[3] In awarding that fee, the ALJ implicitly found that claimant's attorney was "instrumental" in obtaining a rescission of the denial, as required under ORS 656.386(1)(a). On review, the employer argues that claimant's attorney was not instrumental in obtaining its acceptance of the left CTS condition because: it reasonably delayed acceptance of the claim while the claims adjuster was in the process of seeking clarification from a physician that the left CTS condition existed and was compensable; its decision to accept the left CTS was not initiated by claimant's request for hearing and was, instead, made in response to this clarification of the diagnosis and causal relationship; and the ALJ found that "[t]he claim was accepted shortly after the 30-day processing period and no additional legal time or effort was required." Alternatively, the employer argues that the ALJ did not properly consider the factors set forth at OAR 438-015-0010(4).

We are not persuaded by the employer's argument that claimant's attorney was not instrumental in obtaining the acceptance of the left CTS condition. The claims adjuster's November 20, 1997 letter to Dr. Wilson indicates that the investigation of the claim was prompted by the November 1, 1997 demand for acceptance prepared by claimant's attorney. The employer has offered no other reason for its decision to seek confirmation of the left CTS diagnosis and causal relationship. Furthermore, the reasonableness of the employer's investigation of the claim is not relevant in determining whether a fee is authorized under ORS 656.386(1). Accordingly, we find that claimant's attorney was instrumental in obtaining the employer's acceptance of the claim. The limited legal time or effort expended after claimant's demand for acceptance does not support a contrary conclusion. Rather, it is a factor to be considered in determining the amount of the fee.

We turn to claimant's alternative argument that the ALJ did not properly consider the following factors set forth at 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;

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[2] In light of our ruling, we need not address the employer's alternative argument that written documentation of wages is not required unless the calculation of TPD is in issue.

[3] The employer did not issue a timely response to claimant's November 1, 1997 written demand for acceptance of the left CTS. *See* ORS 656.386(1)(b)(B).

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

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

Here, the ALJ explained that the $1,500 attorney fee was based on the factors in OAR 438-015-0010(4), in particular the fact that "[t]he claim was accepted shortly after the 30-day processing period and no additional legal time or effort was required." The employer argues that the ALJ's $1,500 attorney fee is "unjustified" because the ALJ's opinion does not reveal whether the assessment was improperly based on allegedly irrelevant factors under OAR 438-015-0010(4), or on some other appropriate factor under the rule.

There is no evidence in the record that claimant's counsel submitted a statement of services to the ALJ, or that the parties submitted any argument to the ALJ as to how the specific factors should be weighed in determining a reasonable fee. Thus, the ALJ's limited discussion of the factors he considered is not a basis for setting aside the fee. *Russell L. Martin,* 50 Van Natta 313 (1998) (an ALJ is 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 did not submit any argument to the ALJ as to how the factors should be weighed in determining a reasonable fee). *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; 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, both parties have made specific arguments on review as to how the factors should be weighed in determining a reasonable fee. We offer the following analysis in response to those arguments. *Accord McCarthy*, 327 Or at 189 (where the parties have specifically argued how the factors should be weighed in determining a reasonable fee, findings are necessary to assist the appellate reviewer in carrying out a meaningful review of the competing arguments).

We begin by rejecting the employer's argument that the factors involving time devoted to the case, complexity of the issues, and skill of the attorneys are completely irrelevant in light of the ALJ's finding that "[t]he claim was accepted shortly after the 30-day processing period and no additional legal time or effort was required." While the nature of the proceedings was limited, claimant's attorney has submitted a statement of services documenting four hours of work prior to the employer's acceptance of the left CTS condition, including the time expended in reviewing and analyzing the file, drafting the demand for acceptance, and submitting the hearing request. This effort required claimant's attorney to use his substantial experience in workers' compensation law to analyze factual, medical and legal issues of average complexity. We also reject the employer's contention that the factors involving the value of the interest and the benefit to claimant are irrelevant in light of the ALJ's finding that there is no compensation due for the period covered by the delay in acceptance. The value and benefit of the employer's acceptance is not limited to the amount of compensation due prior to the acceptance. Rather, claimant's attorney has secured claimant's right to "post-acceptance" benefits for the left CTS, including surgery, other medical care and potential permanent disability. The value of this interest and benefit is significant. Finally, we note that no frivolous issues or defenses were raised, and there was some risk that claimant's counsel might go uncompensated, given the initial equivocal diagnosis of claimant's left upper extremity symptoms.

After considering these factors, we find that $1,000 is a reasonable fee for claimant's attorney's services in obtaining the acceptance of the left CTS. 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 statement of services), the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated.

Penalties

The employer challenges the ALJ's assessment of a 25 percent penalty for its allegedly untimely production of payroll records. The ALJ assessed this penalty against the employer's January 26, 1998 payment of additional TTD following its recalculation of the TTD rate. Claimant cross-requests review of the ALJ's decision not to assess a penalty or attorney fee for the employer's allegedly unreasonable delay in accepting claimant's right and left CTS. In addition, claimant requests a penalty or attorney fee

for the employer's allegedly unreasonable failure to produce the following additional documents: the ledger showing the rate and payment of TTD; the Form 1502 reflecting the late acceptance of the left CTS; and claimant's personnel file.[4]

Consistent with the following alternative rationale, we affirm the ALJ's assessment of a penalty in the amount of 25 percent of the employer's January 26, 1998 TTD payment, and we assess an attorney fee under ORS 656.382(2) for additional discovery violations.

Pursuant to ORS 656.262(11)(a), if a carrier unreasonably delays the payment of compensation, it shall be liable for an additional amount up to 25 percent of the "amounts then due." Pursuant to ORS 656.382(1), a carrier that unreasonably resists the payment of compensation shall pay to the claimant or the attorney of the claimant a reasonable attorney fee. It is claimant's burden to prove that the carrier acted unreasonably. *Harris v. SAIF*, 292 Or 683 (1982); *Gary Stevens*, 44 Van Natta 1178 (1992). Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *See Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of its delay in payment.

TTD Ledger. We begin our penalty analysis with the employer's allegedly unreasonable failure to produce its TTD ledger. On September 23, 1997, claimant's counsel made a written request for production of "existing ledger information showing any payments made in connection with this claim, including * * * payments for TTD[.]" Claimant requested the TTD ledger to determine whether the employer had made timely payment of TTD at the correct rate. The employer had 15 days to furnish the requested ledger, or until October 8, 1997. *See* OAR 438-007-0015(2). The employer does not challenge claimant's contention that it had not produced the ledger at the time of hearing.

Nor has the employer provided a reasonable explanation for its failure to do so. We reject the employer's argument that a penalty is not warranted because the TTD ledger was not relevant to the issues litigated before the ALJ. We acknowledge that the issue of claimant's correct TTD rate was resolved prior to hearing, when the employer recalculated claimant's TTD rate in January 1998. Nevertheless, claimant's attorney expressly raised the TTD rate issue in a November 1, 1997 letter to the ALJ. The employer's subsequent payment of the correct TTD rate does not excuse its prior failure to comply with claimant's request for documents pertinent to that issue.

Thus, we conclude that the employer acted unreasonably in not producing the TTD ledger after October 8, 1997, and that claimant is entitled to a penalty if there are "amounts then due" during this delay period. The employer's January 26, 1998 TTD payment in the amount of $1,014.23 is an "amount then due" for purposes of assessing a penalty for the employer's failure to produce its TTD ledger. On this basis, we assess a penalty in the amount of 25 percent of the January 26, 1998 TTD payment.

Payroll Records. We next address the employer's contention that the ALJ erred in assessing a penalty for its allegedly untimely production of payroll records. In assessing this penalty, the ALJ relied on OAR 438-007-0015(2), which provides in pertinent part:

> "* * * [T]he 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). Upon *specific demand* by the claimant, payroll records shall be obtained by the insurer from the employer and provided to claimant in the same manner as other documents." (Emphasis supplied).

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[4] The ALJ did not address these additional discovery violations. But the exhibits admitted at hearing include a September 23, 1997 request for production which expressly requests these documents, and a March 3, 1998 affidavit from claimant's attorney attesting that the employer had not provided these documents as of the date of hearing. In addition, on the record at hearing, claimant's attorney identified as an issue "[p]enalties, failure to provide *timely* discovery *as well as failure to provide discovery*." In light of this characterization of the penalty issue on the record and the admitted exhibits, we conclude that claimant requested penalties for these additional discovery violations at hearing. Accordingly, we address these additional penalty issues on review. *Accord Mosley v. Sacred Heart Hosp.*, 113 Or App 234, 237 (1992) (under ORS 656.295(5) and (6), the Board has *de novo* review authority to decide all matters arising from the record).

Here, the ALJ reasoned that claimant's attorney made a "specific demand" for payroll records on September 23, 1997, when it wrote the claims adjuster and requested "[p]ayroll records or other documents from the employer for the twelve months prior to the date of this claim and for the time the claim has been pending." The ALJ further concluded that the employer did not provide claimant's attorney with the requested payroll documents until January 1998. On review, the employer contends that the first and only "specific demand" for payroll records was a November 4, 1997 fax, in which claimant's attorney clarified that he was seeking "time cards." The employer further contends that it provided timely discovery by providing the requested time cards on November 7, 1997.

The record supports the employer's assertion that claimant's November 4, 1997 fax limited the discovery request to "time cards." Thus, we agree that the employer did not act unreasonably in producing additional payroll documents in January 1998. But we do not agree that claimant's November 4, 1997 fax was the first and only "specific demand" for payroll records within the meaning of OAR 438-007-0015(2). We, instead, find that the requisite "specific demand" was made in claimant's earlier September 23, 1997 written request for documents. We rely on claimant's express request for "payroll records," as distinct from a more general request for "medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim(s)."

Once that specific demand for payroll records was made, the employer had 15 days in which to provide all payroll documents or seek clarification as to which particular type of payroll documentation claimant's attorney was requesting. *See* OAR 438-007-0015(2). The employer did not take either action within the requisite 15 days, and it has provided no reasonable explanation for its failure to do so. The fact the employer subsequently requested clarification and thereafter provided time cards does not cure its earlier failure to comply with the September 23, 1997 "specific demand" for payroll records.

Accordingly, we find that the employer acted unreasonably when it did not produce these time cards from October 9, 1997 through November 6, 1997, a period of 29 days. Nevertheless, the employer's January 26, 1998 TTD payment is the only "amount then due" during this delay period. And we have already assessed the maximum 25 percent penalty against this amount for the employer's unreasonable failure to produce its TTD ledger. Accordingly, we have no authority to assess an additional penalty for the employer's untimely production of payroll records. *Accord Kim L. Haragan*, 42 Van Natta 311 (1990) (there is no authority to assess penalties totaling more than 25 percent of the compensation then due).

On the other hand, even where there are no "amounts then due" upon which to base a penalty, an attorney fee may be awarded under ORS 656.382(1) if there has been an unreasonable resistance to the payment of compensation. *Ellis v. McCall Insulation*, 308 Or 74 (1989). Here, the employer's 29-day delay in producing its payroll records resulted in a delay in the recalculation of claimant's TTD rate. We conclude that this delay was an unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1).

Consequently, after considering the factors set forth in OAR 438-015-0010(4), we assess a $150 attorney fee. *Accord Haragan*, 42 Van Natta at 313 (fee assessed for unreasonable delay in discovery, where full 25 percent penalty already assessed against only compensation due). In arriving at this amount, we have particularly considered the time devoted to establishing the employer's unreasonable conduct (as represented by the record), the value of the interest involved, and the nature of the proceedings.

Late Acceptances/Form 1502. We next address claimant's contention that the ALJ erred in not assessing a penalty for the employer's allegedly unreasonable delay in accepting claimant's right and left CTS. The record establishes that the employer did not issue these acceptances in a timely manner. The employer's acceptance of claimant's right CTS on October 29, 1997 was issued 99 days after it received the claim for this condition on July 22, 1997.[5] The employer's December 10, 1997 amended acceptance of bilateral CTS was issued 39 days after claimant's November 1, 1997 request for an amended acceptance.[6]

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[5] Pursuant to ORS 656.262(6)(a), a carrier is required to furnish written notice of acceptance or denial of a claim to the claimant within 90 days after the employer has notice or knowledge of the claim.

[6] Pursuant to ORS 656.262(6)(d), a carrier has 30 days from receipt of a request for an amended acceptance to revise its acceptance notice or make other written clarification in response.

The employer has offered no explanation for its delay in accepting the right CTS, and we find that the delay was unreasonable. We also find that the employer unreasonably delayed its acceptance of the left CTS until December 10, 1997. We reject the employer's argument that it reasonably delayed that acceptance pending medical confirmation of a compensable left CTS condition. In a November 3, 1997 opinion letter to the claims adjuster, Dr. Brett confirmed that the left CTS condition existed and was compensable. In support of that conclusion, Dr. Brett noted that Dr. Watson, the employer's medical examiner, "does discuss bilateral symptoms." The claims adjuster did not request further clarification from Dr. Watson until November 20, 1997. On this record, we conclude that the employer's delayed acceptance of the left CTS was unreasonable.

We also find that the employer acted unreasonably in regard to claimant's request for production of the Form 1502 issued in conjunction with the employer's acceptance of the left CTS. On September 23, 1997, claimant's counsel made a written request for production of all claims documents concerning the processing of claimant's claim. This request encompassed the Form 1502. Claimant's counsel requested this form to determine whether the employer had issued a timely acceptance of claimant's left CTS. The employer had 15 days to furnish this form, or until October 8, 1997. OAR 438-007-0015(2). The employer does not challenge claimant's contention that it had not produced the form at the time of hearing. Nor has the employer provided a reasonable explanation for its failure to do so.

Thus, we conclude that the employer acted unreasonably in not producing the Form 1502 after October 8, 1997. We have concluded above that the employer also acted unreasonably in delaying its acceptance of the right and left CTS from October 21, 1997 through October 29, 1997 and December 2, 1997 through December 10, 1997, respectively. Accordingly, claimant is entitled to a penalty if there are amounts due during these delay periods.

As discussed above, we have already assessed the maximum 25 percent penalty against the employer's January 26, 1998 TTD payment. The record does not establish any additional unpaid TTD during the relevant delay period. Consequently, we have no authority to assess an additional penalty for the employer's unreasonable late acceptances, or its unreasonable failure to produce the Form 1502. But each of these actions is a separate unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1). *Accord Martinez v. Dallas Nursing Home*, 114 Or App 453 (1992). Accordingly, after considering the factors set forth in OAR 438-015-0010(4), we assess a $100 fee for the late acceptance of the right CTS, a $100 fee for the late acceptance of the left CTS, and a $50 fee for the employer's failure to produce the Form 1502.

Personnel File. Finally, we conclude that claimant is not entitled to a penalty or attorney fee for the employer's allegedly unreasonable failure to produce claimant's personnel file. Claimant requested the personnel file to determine if he was terminated for violation of work rules or other disciplinary reasons within the meaning of ORS 656.325(5)(b). In light of our determination above that the employer properly terminated claimant's TTD benefits under that statutory provision, there are no "amounts then due" on which to base a penalty pursuant to ORS 656.262(11), and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee under ORS 656.382(1). *See Lloyd A. Humpage*, 49 Van Natta 1784 (1996) (no entitlement to penalty or assessed fee under ORS 656.382(1) for untimely claims processing where no amounts due at time of unreasonable delay (citing *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 162 (1993).

Finally, we note that claimant is not entitled to an attorney fee on review in regard to the employer's appeal of the ALJ's penalty assessment. *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 26, 1998 is affirmed in part, modified in part, and reversed in part. That portion of the order that awarded claimant procedural temporary total disability compensation commencing February 2, 1998 is reversed. The ALJ's award of an out-of-compensation attorney fee is also reversed. In lieu of the ALJ's award of a $1,500 assessed attorney fee, claimant's attorney is awarded a $1,000 fee, to be paid by the self-insured employer. The employer shall pay claimant a $400 assessed fee under ORS 656.382(1) for its unreasonable discovery violations and unreasonable delay in accepting claimant's compensable conditions. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
KAY E. THOMPSON, Claimant
WCB Case No. 98-00956
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a psychological 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

We affirm the ALJ's ultimate conclusion that claimant has not established a compensable mental stress claim. But we do so based on the following alternative rationale.

Claimant contends that stress associated with her job as a customer service supervisor is the major contributing cause of her diagnosed panic disorder and adjustment disorder with anxiety. Claimant experienced work stress as a result of staff layoffs and increased workloads associated with downsizing. In addition, the implementation of a new computerized phone system in June 1997 created additional work stressors. In particular, claimant and her staff were unable to meet the quicker response times required under the new phone system. As a result, claimant received criticism from her supervisor and her staff, and she grew concerned over disciplinary warnings and the possibility of being terminated. Claimant received training on the new phone system through technical manuals and follow-up instruction by telephone. However, she did not receive the same, on-site training in Portland and Salem that was available to customer service supervisors in other offices. Because of claimant's remote location, the employer concluded that claimant's attendance at these meetings would not be cost efficient.

Claimant has the burden of affirmatively proving a compensable mental stress claim. ORS 656.266. To satisfy her burden of proof, claimant must establish that employment conditions are the major contributing cause of her disorder, and that there is clear and convincing evidence her condition arose out of and in the course of employment. ORS 656.802(2)(a) and 656.802(3)(d). In meeting this burden of proof, claimant cannot rely on: job stresses associated with conditions generally inherent in every working situation; 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. ORS 656.802(3)(b). Stress caused by technological changes and associated retraining can be inherent in every working situation. See *Barbara D. Pacheco*, 46 Van Natta 1499, 1500 (1994) (stress associated with retraining necessitated by technological change generally inherent in every work situation); *Karen M. Colenick*, 46 Van Natta 930 (1994) (new management and administrative procedures are generally inherent in every working situation). But operational changes are not conditions generally inherent in every work situation if the record establishes the absence of reasonable retraining as the major source of a claimant's stress. *See Joy Burke*, 43 Van Natta 1237, 1238 (1991).

The causation issues in this case involve 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). The record includes relevant opinions from Drs. Fried, Jones and Sasser.

Dr. Fried did not address whether stressful work conditions were the *major* contributing cause of claimant's stress disorder. Nor did Dr. Fried identify the new phone system as a work stressor. Rather, he focused on stresses associated with downsizing and concerns over disciplinary action or termination, and the record does not establish that these stresses are not generally inherent in every work situation. *See* ORS 656.802(3)(b). Because Dr. Fried's opinion does not factor out non-excluded employment conditions under ORS 656.802(3), it cannot satisfy claimant's burden of proving a compensable mental disorder. *See Robert Jarvil*, 47 Van Natta 221 (1995); *Mary A. Murphy*, 45 Van Natta 2238 (1993). For the same reason, claimant cannot establish a compensable stress claim based on Dr. Jones' conclusory opinion that claimant's symptoms "appear consistent with stress related to her work." *Id.*

We turn to Dr. Sasser's opinion. Unlike Drs. Fried and Jones, Dr. Sasser identified the new phone system as claimant's primary job stressor. However, Dr. Sasser did not opine that stress attributable to claimant's deficient phone *training* was the major contributing cause of her mental disorder. To the contrary, Dr. Sasser opined that claimant's underlying personality style and limited conceptual and abstract problem solving skills were primarily responsible for her inadequate performance under the new phone system. And while Dr. Sasser suggested that claimant might benefit from further "training", we are not persuaded that he was referring to the specific phone training other customer service representatives received. Rather, we find that Dr. Sasser was recommending training to enhance claimant's general problem solving skills.

Accordingly, we conclude that the medical evidence in this case does not establish that conditions not generally inherent in every work situation are the major contributing cause of claimant's mental disorder. On this basis, we affirm the ALJ's ultimate decision that claimant has not established a compensable mental stress claim.

ORDER

The ALJ's order dated May 15, 1998 is affirmed.

In the Matter of the Compensation of
CARRIE L. DEEL, Claimant
WCB Case No. 97-04819
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's aggravation claim for a herniated L4-5 disc condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

On March 15, 1996, claimant was 3 or 4 months pregnant. She bent over to pick up a box of empty bottles at work, experienced back pain, and sought medical treatment. A nurse practitioner diagnosed "acute back injury," provided medication, and authorized time loss.

On March 22, 1996, claimant reported that her back was better. The nurse practitioner released claimant to work on March 25, 1996, recorded a back examination within normal limits, and opined that claimant's back was "back to normal." (Ex. 5; *see* Ex. 27-3). Claimant returned to work.

Claimant denied backache when she visited the nurse on May 24, 1996. (Ex. 5C). On June 14, 1996, the employer accepted claimant's injury claim for a disabling lumbar muscle strain. Claimant stopped working for the employer that month.

Claimant's July 1996 back and thigh pain were attributed to "pre-term labor." (Exs. 6-OB-1, 6B, 6Ba). Claimant's baby was born on August 18, 1996.

Claimant sought chiropractic treatment for her low back on December 17, 1996. She reported the onset of low-back pain in her third trimester of pregnancy "or sooner." (Ex. 10).

A December 26, 1996 Determination Order closed claimant's injury claim with 11 days of temporary disability and no permanent disability. In late January 1997, the chiropractor filed an aggravation claim on claimant's behalf. In March 1997, Dr. Utterback diagnosed a large central disc protrusion at L4-5. On May 1, 1997, Dr. Treible performed left and right L4-5 laminotomies with discectomy.

On May 27, 1997, the employer denied claimant's aggravation claim. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant proved her aggravation claim, based on claimant's credible testimony and the opinions of Dr. Treible, treating surgeon, and Dr. Duff, examining physician. The employer denies that claimant's accepted strain injury caused her herniated L4-5 disc or that the disc condition constitutes an "actual worsening" of the compensable condition since claim closure. We agree with the employer.

Although we generally rely on the opinion of a worker's treating physician, we do not do so when we find persuasive reasons to discount that opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). In this case, we find such reasons.

We note at the outset that Dr. Treible first examined claimant in April 1997, over a year after the March 15, 1996 compensable injury, and Dr. Duff examined claimant only once --also about a year after the work injury. Thus, Drs. Treible and Duff had no particular advantage in terms of evaluating causation because they did not examine claimant's low back immediately after the work injury.[1]

Based on claimant's history of a sudden onset of low back pain with the work injury and ongoing pain thereafter (and in the absence of "any other reasonable explanation"), Dr. Duff suspected that "[claimant] had more of an injury on March 15, 1996, than was recognized at first." (Ex. 12A-5).

Dr. Treible stated that claimant's "symptoms, history, imaging and physical findings are all consistent with her having developed a herniated disc on 3/15/96 with a slowly evolving pain syndrome eventually culminating in her required surgery on 5/1/97." (Ex. 30-2; *see* Ex. 25). Based on claimant's age (21), Dr. Treible found a significant contribution from degenerative disc disease unlikely. He also suspected that claimant's pregnancy had delayed diagnosis and treatment of the disc herniation. (Ex. 30-2).

Claimant testified that she had ongoing low back pain ever since the March 1996 lifting incident at work. (Tr. 12-13, 18, 20, 26-28, 30-32). The opinions of Drs. Duff and Treible are based, in significant part, on this history. But claimant's testimony in this regard is at odds with the contemporaneous medical records.[2]

Claimant reported that her back was "better" 12 days after the 1996 strain injury and her nurse practitioner opined that the injury was "healing." (Ex. 4). On March 25, 1996, claimant's back examination was within normal limits and the nurse recorded that claimant's back was "back to normal." (Ex. 5). March 22, 1996 was the last date claimant mentioned back symptoms (other than those referable to pregnancy) for almost nine months. In fact, claimant *denied* any backache on May 24, 1996. This evidence of "quick recovery" in March 1996 is inconsistent with claimant's testimony and her reporting to Drs. Duff and Treible. (*See* Exs. 23-7, 23-9, 28-2-3).

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[1] *See McIntyre v. Standard Utility Contractors, Inc.*, 135 Or App 298, 302 (1995) ("A treating physician's opinion [ ] is less persuasive when the physician did not examine the claimant immediately following the injury."); (citing *Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986); *Marshall v. Boise Cascade*, 82 Or App 130, 134 (1986); *William D. Brizendine*, 50 Van Natta 21, 22 (1998); *compare Givens v. SAIF*, 61 Or App 490, 494 (1983).

[2] We generally defer to the ALJ's demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990). However, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of the record. *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Davies v. Hanel Lumber Co.*, 67 Or App 35 (1984); *Timothy D. McCune*, 47 Van Natta 438 (1995). Inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. *See Gail A. Albro*, 48 Van Natta 41, 42 (1996); *Angelo L. Radich*, 45 Van Natta 45 (1993). Where a claimant's reporting is inconsistent or incomplete, a medical opinion based on that reporting is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); *James D. Shirk*, 41 Van Natta 90, 93 (1989) (A physician's opinion based on a patient's history is only as reliable as the history is accurate).

Claimant testified that she did not seek treatment for her back during her pregnancy because she understood that nothing could be done for her back while she was pregnant. (Tr. 12; *see* Ex. 14). But claimant's baby was born on August 18, 1996, and claimant did not seek treatment for her low back until December 17, 1996, another four months later. In our view, the contemporaneous medical record does not support claimant's testimony regarding ongoing symptoms or Dr. Treible's theory of a "slowly evolving pain syndrome" (which is based on a history of ongoing symptoms). (*See* Ex. 30). Moreover, if claimant was experiencing chronic back pain throughout her pregnancy, we find it likely that she would have mentioned those symptoms (even if she understood that nothing could be done for it) sometime during her numerous gynecological examinations.[3] Under these circumstances, we cannot say that the opinions of Drs. Duff and Treible are based on a materially accurate history or that they are persuasive. *See Rob R. Hartley,* 49 Van Natta 2011 (1997) (Physician's causation opinion unpersuasive because based on inaccurate clinical history).

Dr. Fuller provides the contrary medical evidence. If claimant had a herniated disc in 1996, Dr. Fuller explained that she would not have avoided low back pain during her pregnancy. He noted that claimant's medical records indicate that the work injury was a simple strain that resolved quickly. Based on the nature of the injury and the lack of medical evidence of ongoing problems, Dr. Fuller concluded that claimant's herniated disc (diagnosed a year later) was unrelated to the work injury. (Ex. 28; *see* Ex. 23). We find Dr. Fuller's reasoning and conclusions persuasive, because they are based on an accurate history and more consistent with claimant's clinical history (as recorded contemporaneously) than are those of the treating physicians. Under these circumstances, we conclude that claimant has not established that her recent L4-5 herniated disc condition is compensably related to her accepted lumbar strain condition. Accordingly, claimant's aggravation claim must fail.[4] *See* ORS 656.273.

ORDER

The ALJ's order dated July 20, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] We also note that claimant's testimony that she left work in June "because of her back" is similarly unsupported in the contemporaneous medical records.

[4] We also note that the claim would fail because claimant has not established that her condition actually worsened *since claim closure.*

In the Matter of the Compensation of
CURTIS R. STEPHENS, Claimant
WCB Case No. 98-01552
ORDER DENYING RECONSIDERATION
Daniel Snyder, Claimant Attorney
Jacqueline A. Weber, Defense Attorney

On October 28, 1998, we affirmed an Administrative Law Judge's (ALJ's) order. On December 2, 1998, we received a November 30, 1998 letter from the Court of Appeals, which enclosed a November 25, 1998 letter from claimant's counsel that was addressed to the court. Claimant's counsel's letter stated that claimant's "Motion to Abate and Reconsider" was enclosed. Assuming, without deciding, that claimant's counsel's letter constitutes a request for reconsideration of our October 28, 1998 order, we conclude that the request is untimely.

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 October 28, 1998 order was November 27, 1998. Although claimant's counsel's letter was dated within 30 days of our October 28, 1998 order, we did not receive it until December 2, 1998. Thus, by the time of our receipt of that request, the 30-day statutory period for reconsideration of our decision had expired.

Inasmuch as our October 28, 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. *See* ORS 656.295(8); *International Paper Co. v. Wright, supra; Fischer v. SAIF, supra; Donald J. Bidney*, 47 Van Natta 1097 (1995). Consequently, we lack authority to consider claimant's request to abate and reconsider our order.

Accordingly, claimant's motion for abatement and reconsideration is denied.[1]

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. *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
JEFFREY S. DECLUE, Claimant
WCB Case Nos. 98-04007 & 98-03777
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's partial denial of claimant's spondylolisthesis condition at L5-S1. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

On October 13, 1997, claimant, who worked as a mechanic, compensably injured his low back while pushing a disabled car. That night, claimant went to the Emergency Room where x-rays revealed bilateral L5 pars interarticularis defects, a grade I spondylolisthesis at L5-S1, mild to moderate L4-5 disc space narrowing, and mild L5-S1 disc space narrowing. (Ex. 1). An acute lumbar strain was diagnosed and claimant was treated conservatively. On October 27, 1997, SAIF accepted a disabling low back strain injury. (Ex. 9).

On October 29, 1997, a CT scan revealed, among other conditions, a "[b]ilateral pars defect of L5 creating a grade I-II spondylolisthesis of L5 on S1." (Ex. 10). On December 1, 1997, a bone scan revealed "[m]inimal changes at L5-S1, consistent with DJD [degenerative joint disease]. No evidence for pars interarticularis fracture. Otherwise, negative scan." (Ex. 19).

On January 30, 1998, Dr. Jenkins first examined claimant. Until that time, claimant had primarily treated with Dr. Rabie, M.D., although he had also been seen in consultation by Dr. Tahir, neurosurgeon, and Dr. Corrigan, orthopedist. After failing to respond to conservative treatment, on April 1, 1998, claimant underwent a posterior lateral spinal fusion with iliac bone graft and internal fixation at L5-S1 performed by Drs. Stark, M.D., and Jenkins. (Ex. 34B).

On April 30, 1998, Drs. Williams, neurosurgeon, and Schilperoort, orthopedist, examined claimant on behalf of SAIF.

CONCLUSIONS OF LAW AND OPINION

As the ALJ found, only the opinion of Dr. Jenkins, claimant's current treating physician and surgeon, might support compensability of claimant's claim. The ALJ found Dr. Jenkins' opinion unpersuasive. Therefore, the ALJ concluded that claimant failed to prove compensability of his spondylolisthesis condition. We agree.

Claimant argues that the ALJ found Dr. Jenkins' opinion unpersuasive based on a mistaken belief that Dr. Jenkins had an inaccurate history of claimant having no low back symptoms before the October 13, 1997 work injury. Claimant argues that Dr. Jenkins' history was accurate because any prior low back symptoms claimant might have had were due to muscular soreness after exercise, and he did not have any prior low back injuries or any prior medical treatment for low back symptoms. Furthermore, claimant argues that only Dr. Jenkins' opinion is well-reasoned. We disagree. Even disregarding any problems with claimant's history regarding prior low back symptoms, we find Dr. Jenkins' opinion insufficient to meet claimant's burden of proof.

Based on the preponderance of the medical evidence, we find that claimant had a preexisting condition of spondylolisthesis at L5-S1 with bilateral pars defect that combined with his October 1997 lumbar strain injury to cause or prolong claimant's disability and the need for treatment. (Exs. 7, 16, 21-1, 20-3-4, 42, 46, 49A).

Consequently, claimant must prove that his October 13, 1997 work injury was the major contributing cause of his disability or need for medical treatment for his combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 104 Or App 309 (1997); *Gregory C. Noble*, 49 Van

Natta 764, 767 (1997). The fact that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily mean that the 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.* Furthermore, given the combination of the preexisting spondylolisthesis condition and the work injury, 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).

Generally, deference is given to the treating physician who was able to observe the affected body part during surgery. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988). However, although Dr. Jenkins performed claimant's surgery, he does not relate any surgical observations to his causation opinion.[1] Therefore, his status as surgeon does not add any weight to his opinion. We also generally defer to the opinion of the treating physician unless there are persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, there are persuasive reasons not to defer to Dr. Jenkins' opinion.

When Dr. Jenkins first examined claimant, he stated that claimant's "spondylolysis does not appear to be congenital in nature but appears to be more traumatic and this is consistent with his history and his symptoms." (Ex. 26-2). Dr. Jenkins noted that claimant reported being treated at Emanuel Hospital in 1987 for a motorcycle accident that resulted in a right tibia fracture. (Ex. 26-1). Claimant also reported that x-rays of his back at that time were normal. (Ex. 26-2). Dr. Jenkins diagnosed "[p]ossible traumatic L5-S1 spondylolisthesis" and noted that he would send for and examine claimant's x-rays from Emanuel Hospital.

Thus, Dr. Jenkins first opined only that there was a "possible" traumatic L5-S1 spondylolisthesis, but he needed to review previous x-rays from Emanuel Hospital. (Ex. 26). Subsequently, without any evidence that he had examined those prior x-rays, Dr. Jenkins changed his opinion from a "possible" traumatic spondylolisthesis to stating that the work injury caused the slippage and was the major cause of the need for surgery. (Ex. 32). Dr. Jenkins did not explain this apparent change of opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

In his next causation opinion, Dr. Jenkins disagreed with Drs. Schilperoort's and Williams' opinion[2] and stated that the main question was whether the condition was traumatic or preexisting spondylolysis and that the question was moot because the injury of October 1997 "was the proximate cause of [claimant's] pain and disability leading to surgical treatment." (Ex. 49). But this explanation is no more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda*, 130 Or App at 401.

Finally, Dr. Jenkins noted that he did not believe that the bone scan was conclusive in determining the age of any pars interarticular fracture, opining that the bone scan would not show increased uptake even if a recent fracture were present, if the bone at that site had some abnormality prior to the fracture at the time of the work injury. (Ex. 50A-1). Dr. Jenkins also opined that one of two events occurred at the time of claimant's work injury, but he could not tell which of the two possible events occurred. (Ex. 50A-2). He explained that the first possibility was that the pars interarticularis fracture occurred at the time of the work injury, resulting in slippage and the onset of symptoms and ultimate need for surgery. The second possibility was that the fracture was preexisting, but scar tissue had formed at the site of the fracture and was holding claimant's spine in alignment, and that the scar

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[1] *Compare Argonaut Insurance Company v. Mageske*, 93 Or App at 702 (treating surgeon's opinion found persuasive where he was able to observe the claimant's shoulder during surgery and indicated that there was no evidence that the claimant's condition was due to congenital defect); *Givens v. SAIF*, 61 Or App 490, 494 (1983) (treating surgeon's opinion found persuasive where he indicated that he saw no evidence during surgery that the claimant's thoracic outlet syndrome was the result of a congenital defect or a compressed artery).

[2] Drs. Schilperoort and Williams opined that claimant's spondylolisthesis at L5-S1 was an old and preexisting condition because the bone scan did not show evidence of a pars interarticular fracture. (Ex. 42-5). They also noted that the bone scan did not indicate any active bone metabolism at the level of spondylolisthesis, which indicated a nontraumatic origin. (Ex. 42-6). They stated that claimant's preexisting condition combined with the work injury and the preexisting condition was the major contributing cause of claimant's current treatment.

tissue was disrupted by the October 1997 work injury. (*Id.*). He stated that the work injury was the major contributing cause of either the fracture or the disruption of scar tissue. (*Id.*). We note that, under this second theory, Dr. Jenkins' opinion suggests that the work injury combined with a preexisting condition to cause the need for treatment.

This final opinion also fails to meet claimant's burden of proof. In this regard, if there was a preexisting fracture that was stabilized by scar tissue, Dr. Jenkins does not evaluate the relative contribution of those preexisting conditions and the work injury to determine the primary cause of claimant's need for treatment, as *Dietz* requires. Thus, Dr. Jenkins' final causation opinion is unpersuasive because his explanation of his second theory does not meet the *Dietz* standard. Because Dr. Jenkins could not determine which theory was correct, if either theory is unpersuasive, it stands to reason that the opinion as a whole is unpersuasive.

Thus, we find Dr. Jenkins' various causation opinions unpersuasive. Because no other medical opinion supports compensability of the combined low back condition, we find that claimant has failed to meet his burden of proof.

ORDER

The ALJ's order dated August 14, 1998 is affirmed.

December 10, 1998 Cite as 50 Van Natta 2317 (1998)

In the Matter of the Compensation of
RUTH L. EASLEY, Claimant
WCB Case No. 98-02820
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a right thumb arthritis condition; and (2) assessed a $3,500 attorney fee. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order[1] with the following supplementation regarding the attorney fee issue.

SAIF contends that the ALJ made no findings and provided no reasoning to explain her attorney fee award. SAIF does not contend that the ALJ's attorney fee is excessive, only that there is insufficient information to determine an appropriate fee amount. We disagree, as explained herein.

The record contains no specific attorney fee request (or statement of services), nor does it appear that the parties submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. We have determined that, under such circumstances, the ALJ is not obligated to make specific findings regarding the rule-based factors, in order to have a reviewable order. *See Steven D. Sambuceto*, 50 Van Natta 1812, 1813-14 (1998); *Russell L. Martin*, 50 Van Natta 313 (1998) (finding that the absence of a fee request or argument on the rule-based factors distinguishes a case from *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), which required a "sufficient explanation" of how the rule-based factors were weighed in deciding that a "reasonable" fee was substantially less than the amount requested).[2]

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[1] *See Esther L. Mace*, 48 Van Natta 1168 (1996) (Where no evidence indicated that the claimant's condition preexisted her more than twenty-year work exposure, she was not required to prove that work was the major contributing cause of a combined condition and worsening of a preexisting condition to establish a compensable occupational disease); *Delbert D. Shuck, Sr.*, 47 Van Natta 248 (1995) (same).

[2] Our *en banc* decision in *Martin* issued February 27, 1998. Because *Martin* provides the Board's interpretation of *Schoch*, we would expect to receive for review a discussion of the reasoning expressed in *Martin*. But SAIF has neither discussed nor distinguished the *Martin* holding.

Nonetheless, because SAIF has now advanced arguments challenging the sufficiency of the ALJ's order and because 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.

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 issue in dispute was the compensability of claimant's right thumb arthritis condition.

Approximately 16 exhibits were received into evidence, with at least 3 generated and submitted by claimant. The hearing lasted about 35 minutes, with a transcript consisting of approximately 18 pages. Claimant was the only witness who testified.

The case involved issues of medical complexity within the range of those submitted to this forum for resolution. The claim's value and the benefits secured are comparable to those this forum generally encounters. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a substantial risk that claimant's counsel's efforts might have gone uncompensated, considering the potential legal complexity of the case and claimant's burden of proof.

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 claimant's counsel's services at the hearings level. 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.

Claimant's attorney is entitled to an assessed fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $600, 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. Finally, we note that claimant is not entitled to an attorney fee for services related to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 4, 1998 is affirmed. For services on review, claimant is awarded a $600 attorney fee, payable by the SAIF Corporation.

December 10, 1998 Cite as 50 Van Natta 2318 (1998)

In the Matter of the Compensation of
JACKIE T. GANER, Claimant
WCB Case No. 97-09610
ORDER OF ABATEMENT
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of the Board's November 12, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of claimant's mental disorder claim. The employer has filed a response to claimant's motion.

In order to allow sufficient time to further consider this matter, the Board's November 12, 1998 order is withdrawn. After completion of this reconsideration, the Board shall issue its decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFERY J. KESTERSON, Claimant
WCB Case No. 98-02732
ORDER ON REVIEW
Lavis & DiBartolomeo, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant did not timely file a claim for his alleged right shoulder injury; and (2) upheld the SAIF Corporation's denial of his right shoulder injury claim. On review, the issues are timeliness and compensability.

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

The ALJ upheld SAIF's denial of claimant's right shoulder injury claim, finding both that the claim was untimely filed and that SAIF's denial was proper on the merits. On review, claimant contends that the employer had knowledge of his injury when it occurred and that the medical evidence establishes that his claim is compensable.

We need not address the timeliness issue because, even if the claim was not time-barred, we agree with the ALJ and SAIF that claimant failed to prove that he suffered a compensable injury. We reach this conclusion for the following reasons.

There are two medical opinions that address causation: those of Dr. Peterson and Dr. Woodward. Dr. Peterson treated claimant one time on January 29, 1998 for right shoulder complaints that allegedly resulted from an injury occurring more than six months earlier on July 15, 1997, when a power saw fell from a ledge and struck claimant's right shoulder. (Ex. 18). Dr. Peterson did not provide a diagnosis, but did note a positive impingement sign and a mildly positive biceps aggravation test. *Id.* On June 23, 1998, Dr. Peterson opined that the alleged July 15, 1997 injury was the major contributing cause of claimant's right shoulder condition and need for treatment because of a clear history of trauma and because of the absence of prior problems. (Ex. 27).

Dr. Woodward, who examined claimant at SAIF's request on May 21, 1998, provided a detailed response to Dr. Peterson's report. (Ex. 28). Dr. Peterson reported that it was unclear whether claimant had an impingement syndrome. But if claimant did have such a condition, according to Dr. Woodward, it was an idiopathic condition probably unrelated to the July 15, 1997 injury. Dr. Woodward also noted claimant's report that he developed a large bruise over the right scapula, but Dr. Woodward noted that the bruise was not present on examination or mentioned in Dr. Peterson's chart note. This suggested to Dr. Woodward that any contusion had healed long before Dr. Peterson's examination on January 29, 1998. Moreover, Dr. Woodward opined that the mechanism of injury was not consistent with claimant's complaints or examination findings. Dr. Woodward emphasized that the July 15, 1997 incident was not responsible for claimant's complaints in January 1998 and thereafter.

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); *see Mark N. Weidle*, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

Considering the passage of time between the date of the alleged injury and claimant's seeking 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 persuasive reasons not to rely on Dr. Peterson's opinion.

Dr. Peterson saw claimant only once for his right shoulder condition, more than six months after the alleged work injury. Under these circumstances, we cannot say that Dr. Peterson was in a more advantageous position as attending physician to render an opinion regarding the relationship between the July 1997 injury and the current shoulder condition. *See McIntyre v. Standard Utility Contractors*, 135 Or App 298, 302 (1995) (A treating physician's opinion is less persuasive when the physician did not examine the claimant immediately following the injury). In addition, we do not find Dr. Peterson's opinion to be as well-reasoned as that of Dr. Woodward, who provided a thorough response to Dr. Peterson's opinion. Because it is well-reasoned and based on a complete and accurate history, we find Dr. Woodward's opinion more persuasive than Dr. Peterson's.

Accordingly, we agree with the ALJ that claimant failed to prove that the alleged July 1997 incident was a material contributing cause of the medical treatment provided on January 29, 1998. Therefore, we affirm.

ORDER

The ALJ's order dated July 27, 1998 is affirmed.

In the Matter of the Compensation of
DOUGLAS NIEMI, Claimant
WCB Case No. 98-02887
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that awarded an attorney fee under ORS 656.386(1) for claimant's attorney's efforts in obtaining rescission of his claim for a C5-6 disc herniation. On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the fourth paragraph on page 2, we change the third sentence to refer to a "disc protrusion at T7-8." In the seventh paragraph on page 2, we change the date in the second sentence to "June 17, 1998."

We agree with the ALJ's reasoning and conclusion that claimant is entitled to a fee under ORS 656.386(1). The employer's alternative argument is that the $1,500 fee awarded by the ALJ was excessive.

ORS 656.386(1) provides that, "[i]n such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed." We determine the amount of claimant's counsel's attorney fee for services at the hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issue in dispute was compensability of claimant's C5-6 disc herniation condition. Sixty-seven exhibits were received into evidence, five of which were generated by claimant's counsel. There were no depositions. Claimant's attorney submitted an affidavit indicating he spent 12 hours on the case, not including the time at hearing. The ALJ noted that some portion of claimant's attorney's time was devoted to issues that were withdrawn by claimant before the hearing.

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[1] We change the ALJ's order to reflect that Exhibits 46A and 46B, rather than Exhibits 46A through 46C, were admitted into evidence.

Because claimant's C5-6 disc herniation is compensable, he is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The value of the claim may potentially include permanent disability benefits. The nature of the proceeding was relatively uncomplicated as it concerned a prehearing rescission. There was a significant risk that claimant's counsel's efforts might go uncompensated. After considering these factors, we agree with the ALJ that $1,500 is a reasonable attorney fee award in this case. We note that 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 August 4, 1998 is affirmed.

Board Member Moller dissenting.

In adopting and affirming the ALJ's order, the majority holds that claimant's attorney's December 29, 1997 letter satisfied the requirements of ORS 656.262 and, therefore, claimant's attorney is entitled to an attorney fee under ORS 656.386(1). Because the majority's conclusion is inconsistent with the facts and the statutes, I respectfully dissent.

Claimant was compensably injured on May 19, 1997. On June 24, 1997, the employer accepted a nondisabling claim for lumbar and cervical strains. (Ex. 12A). The acceptance was amended on June 27, 1997 to include contusions of the right leg and left shoulder. (Ex. 13B). On July 26, 1997, the insurer accepted a dorsal strain. (Ex. 18A). An MRI in July 1997 revealed a small focal disc herniation at C5-6. (Ex. 17A). On August 21, 1997, Dr. Puziss included a diagnosis of a small right C5-6 disc herniation. (Ex. 22).

On December 29, 1997, claimant's attorney wrote to the employer's processing agent, stating, in part:

> "All denials, de facto denials, and processing issues are placed at issue. The carrier is requested to classify the claim as disabling and to recalculate time loss. The carrier is requested to direct appropriate appeals whenever denials or processing orders are issued so that time deadlines are not missed. Unaccepted conditions listed by examining or treating physicians as resulting from this claim should receive formal written acceptance including at least shoulder, cervical, thoracic, lumbar, and leg sprains and strains, chronic pain and chronic pain syndrome, disc and vertebral injuries, anxiety, depression, nerve injuries and impingements." (Ex. 35A).

Because the December 29, 1997 letter did not satisfy the requirements of either ORS 656.262(7)(a) or 656.262(6)(d) by making a claim for a C5-6 disc herniation, claimant's attorney is not entitled to an attorney fee under ORS 656.386(1).

Claimant did not satisfy ORS 656.262(7)(a), which requires that he must clearly request formal written acceptance of a C5-6 disc herniation. ORS 656.262(7)(a) provides, in part:

> "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."

Claimant's attorney's December 29, 1997 letter is anything but a clear request for formal written acceptance of a new medical condition. To the contrary, the letter merely referred to "disc and vertebral injuries" and did not clearly request formal written acceptance of a C5-6 disc herniation. The letter requested "formal written acceptance" of "[u]naccepted conditions listed by examining or treating physicians as resulting from this claim." (Ex. 35A). At the time of the December 29, 1997 letter, no physician had diagnosed a disc injury or a vertebral injury. Although Dr. Puziss had diagnosed a C5-6 disc herniation, he had not indicated as of December 29, 1997 that the herniation had resulted from the compensable injury.

Given it's text and context, the intent of ORS 656.262(7)(a) was to require written communication which, independent of reference to various medical reports or billings, clearly requires acceptance of an express condition. Claimant's attorney's blanket request for acceptance-among a host of other conditions-of "disc and vertebral injuries" is insufficient. Furthermore, the December 29, 1997 letter appears to be a generic letter that contains several inaccurate statements. Many of the conditions listed in the letter had already been accepted and some of the listed condition had not been diagnosed. The letter also made a demand for "denial rates statistics kept on the adjuster and company who have authored the denial at issue[.]" (Ex. 35A-2). As of December 29, 1997, no denial had been issued in this case.

Furthermore, claimant's reliance on ORS 656.386(1)(b)(B) is misplaced. ORS 656.386(1)(b)(B) refers to a "denied claim" as "[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[.]" Even if ORS 656.262(6)(d) applies to these facts, there is no evidence that claimant objected to the notice of acceptance or requested that it be amended. 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."

Because claimant did not satisfy the requirements of either ORS 656.262(7)(a) or 656.262(6)(d) by making a claim for a C5-6 disc herniation, he has not established the conditions necessary for entitlement to an attorney fee under ORS 656.386(1). Claimant's attorney's "blanket" approach is inconsistent with legislative intent and should be discouraged. Claimant's attorney is not entitled to an attorney fee in this case.

In the Matter of the Compensation of
BETTY M. SIEMERS, Claimant
WCB Case No. 98-03692
ORDER ON REVIEW
Westmoreland & Mundorff, 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 her injury claim for a cervical condition. On review, the issue is compensability.

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

The ALJ upheld SAIF's denial of her C5-6 herniated disc condition, finding that none of the physicians who addressed medical causation had an accurate history. On review, claimant contends that Dr. Brett, who opined that claimant's work activity on December 16, 1997 was the major contributing cause of her cervical herniated disc, had an accurate history and, hence, provided a persuasive medical opinion. We disagree.

Dr. Brett reported that claimant had denied prior neck or arm difficulties, except for occasional aches and pains from overexertion. (Ex. 6-1). Claimant, however, had earlier given a history to another physician of ongoing left arm pain for six to eight months. (Ex. 1). Moreover, claimant testified that she first experienced left arm symptoms for four or five months prior to seeking medical treatment for the December 16, 1997 injury. (Tr. 4). Based on this evidence, we agree with the ALJ that Dr. Brett did not have an accurate history regarding the development of upper extremity symptoms. In addition, Dr. Brett reported that claimant lifted 60 to 100 pounds on the date of injury. (Ex. 6-1). But claimant testified that she lifted only 15 or 30 pounds. (Tr.4). For this additional reason, we conclude that Dr. Brett had an inaccurate history and, thus, that his opinion is not persuasive. *See Miller v. Granite Construction*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

ORDER

The ALJ's order dated August 26, 1998 is affirmed.

December 11, 1998 Cite as 50 Van Natta 2323 (1998)

In the Matter of the Compensation of
BONNIE L. BURSELL, Claimant
WCB Case No. 98-00546
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order that affirmed an Order on Reconsideration insofar as it did not award unscheduled permanent disability for a cervical condition. On review, the issue is the extent of unscheduled permanent disability. 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 replace the second sentence with the following:

> "Dr. Bolin found that claimant was entitled to an award of 3 percent permanent disability for her cervical condition. (Exs. 3, 4, 6). He attributed 66 percent of the impairment to the December 8, 1996 work incident and 34 percent to the preexisting spondylosis. (Exs. 4, 6)."

In the third paragrah of page 2, we change the last portion of the paragraph to read:

> "The Appellate Unit's 'Medical Arbiter Questions' requested that the arbiters "perform a complete examination of neck, mid-back and describe any objective findings of permanent impairment resulting from the accepted condition(s) including, but not limited to, the following: * * *." (Ex. 9A-2; emphasis in original).

CONCLUSIONS OF LAW AND OPINION

Cervical Impairment

Claimant compensably injured her neck and upper shoulder on December 8, 1996. SAIF accepted a claim for cervical strain/sprain and thoracic strain/sprain. (Ex. 7). Dr. Bolin, the attending physician, performed a closing examination on February 3, 1997. (Ex. 3). A Notice of Closure issued on August 21, 1997, awarding 3 percent unscheduled permanent disability for the cervical spine. (Ex. 8). Claimant requested reconsideration. (Ex. 9). A medical arbiter examination was performed on December 6, 1997. (Ex. 10). A January 2, 1998 Order on Reconsideration reduced claimant's unscheduled award for cervical impairment to zero. (Ex. 11).

The ALJ found that there was no medical evidence that claimant's injury "combined" with the preexisting cervical spondylosis and, therefore, determined that the Appellate Review Unit acted properly in disregarding claimant's measured losses in cervical ranges of motion.[1]

On review, claimant contends that she is entitled to a 10 percent impairment value of unscheduled permanent disability for reduced cervical range of motion. She acknowledges that she has preexisting cervical spondylosis. Citing OAR 436-035-0007(3)(c), she contends that apportionment of disability is not appropriate because SAIF has not issued a "major contributing cause" denial pursuant to ORS 656.262(7)(b).

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[1] Although the ALJ also awarded 5 percent unscheduled permanent disability for claimant's reduced range of motion in her thoracic spine, neither party raises that issue on review.

On the other hand, SAIF argues that claimant failed to prove that she sustained a combined condition that would have required a pre-closure denial under ORS 656.262(7)(b).

The reports from the medical arbiter panel, as well Dr. Bolin, claimant's attending physician, establish that claimant's cervical spondylosis constitutes a "preexisting condition" under ORS 656.005(24). (Exs. 4, 6, 10). Nevertheless, there is no medical evidence establishing that claimant's preexisting cervical spondylosis "combined" with the work injury. Although Dr. Bolin referred to claimant's "preexisting impairment" from preexisting spondylosis (Ex. 4), he did not discuss whether the work injury "combined" or was superimposed on the cervical spondylosis condition.

Similarly, the medical arbiter panel did not discuss a "combining" of the preexisting cervical spondylosis and the compensable injury. Rather, they attributed claimant's reduced range of cervical motion to the preexisting spondylosis, without any contribution from the work injury. (Ex. 10-4, -5).

Based on these reports, we conclude that claimant's cervical disability is solely caused by her preexisting cervical spondylosis. *See* ORS 656.225.[2]

Moreover, contrary to claimant's assertion, OAR 436-035-0007(3)(c)[3] has no application in this case because there is no evidence that claimant's compensable condition has combined with a preexisting condition. Therefore, we agree with the ALJ that claimant is not entitled to a permanent disability award for reduced cervical range of motion.

ORDER

The ALJ's order dated June 5, 1998 is affirmed.

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[2] ORS 656.225 provides:

"In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:

"(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.

"(2) In occupational disease or injury claims involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of an actual worsening of the preexisting condition and not just its symptoms.

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

In the present case, none of the exceptions to ORS 656.225 are applicable.

[3] OAR 436-035-0007(3)(c) (WCD Admin. Order No. 96-072) provides, in part:

"Where a worker's compensable condition combines with a preexisting condition, pursuant to ORS 656.005(7), the current disability resulting from the total combined condition shall be rated in accordance with these rules as long as the compensable condition remains the major contributing cause of the combined condition, *i.e.*, a major contributing cause denial has not been issued pursuant to ORS 656.262(7)(b). Apportionment of disability is not appropriate."

In the Matter of the Compensation of
KENT L. COLEMAN, Claimant
WCB Case No. 97-03457
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Martha J. Brown's order affirming an Order on Reconsideration that affirmed a Notice of Closure that awarded no unscheduled or scheduled permanent disability for claimant's left shoulder and left elbow injury. On review, the issues are unscheduled and scheduled permanent disability.

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

The ALJ determined that claimant had failed to establish that he sustained permanent impairment due to his compensable left shoulder and elbow injury. In so doing, the ALJ relied on the medical opinion of claimant's attending physician, Dr. Grewe, who opined that claimant's shoulder symptoms were primarily due to noncompensable cervical spine pathology. (Exs. 20, 25A).

On review, claimant contends that we should instead rely on the medical opinion of examining physicians, Drs. Labs and Morton, with whose report Dr. Grewe concurred and whose opinion claimant asserts establishes compensable left shoulder impairment. We disagree with claimant's contention that the Morton/Labs report satisfies her burden of proof.

SAIF accepted a left shoulder strain and left elbow epicondylitis as a result of claimant's compensable December 14, 1995 injury. Claimant now seeks permanent disability for a left shoulder impingement condition based on the Morton/Labs report, which indicated that claimant has reduced range of motion due to "residual impingement of the left shoulder." (Exs. 22, 23).

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.[1] 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.

Here, claimant's left shoulder impingement condition is not an accepted condition. Unless it is a "direct medical sequela" of the accepted left shoulder or elbow conditions, claimant is not entitled to permanent disability based on the impingement condition. Based on our *de novo* review of the record, we find that the preponderance of the medical evidence does not establish that claimant's left shoulder impingement condition is a direct medical sequela of the accepted conditions.

While Drs. Morton and Lab stated that claimant has residual impingement of the left shoulder, they also stated that the accepted left shoulder strain had resolved. (Ex. 23-2). Drs. Morton and Labs did not clarify whether the residual left shoulder impingement was a sequela of the accepted conditions or was related to the accidental injury. *Cf. Donald D. Davis*, 50 Van Natta 357 (1998) (no permanent disability awarded for unaccepted epicondylitis condition where the claimant failed to show that the elbow condition was direct medical sequela of accepted elbow contusion). Moreover, Dr. Grewe opined that claimant had secondary impingement from decreased motion. The primary cause of this, however, was claimant's cervical spine pathology. (Ex. 25A). Finally, Dr. James, the medical arbiter, diagnosed an impingement syndrome of the left shoulder, but he did not address whether it was due to the accepted injury or whether it was the result of the accepted conditions. (Ex. 26A).[2]

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[1] ORS 656.268(16) provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

[2] Dr. James reported that the accepted conditions were "100% related to the industrial injury." (Ex. 26A-4). Earlier in his report, he noted that the accepted conditions were "left shoulder strain and a left elbow medial epicondylitis." (Ex. 26A-1).

Thus, having found that claimant failed to show that the left shoulder impingement condition is a "direct medical sequela" of the accepted conditions, we conclude that he is not entitled to permanent impairment based on the impingement condition. *See* ORS 656.268(16); *Julio C. Garcia-Caro*, 50 Van Natta at 163.

ORDER

The ALJ's order dated April 30, 1998 is affirmed.

December 11, 1998 Cite as 50 Van Natta 2326 (1998)

In the Matter of the Compensation of
MONIKA M. GAGE, Claimant
WCB Case No. 98-01440
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the self-insured employer's denial of her left arm and neck injury claim; 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.

The ALJ upheld the employer's denial of claimant's injury claim, finding that medical evidence addressing causation was based on an inaccurate or incomplete history, with the exception of that which Dr. Garrett, her family physician, provided. Acknowledging that Dr. Garrett was aware of claimant's preexisting left arm and neck complaints, the ALJ nevertheless discounted Dr. Garrett's opinion because it was not objective and poorly reasoned.

On review, claimant contends that the medical evidence from the physicians who addressed causation should satisfy her burden of proof. In so doing, claimant cites Dr. Garrett's October 29, 1997 medical report in which he concludes that claimant's onset of symptoms on September 16, 1997 was "work-related." (Ex. 26B). The employer objects to consideration of this report as "substantive" evidence because the report was admitted as "impeachment" evidence.

We agree with the employer that Dr. Garrett's report was offered by the employer and admitted as impeachment evidence. (Tr. 43). Claimant's attorney did not object to the report's admission or to the ALJ's characterization of it as "impeachment" evidence. Moreover, claimant did not offer the withheld evidence as substantive evidence. *See* OAR 438-007-0017(3) (impeachment evidence shall not be considered as substantive evidence unless the opposing party offers the withheld evidence as substantive evidence).[1]

Under these circumstances, we are not inclined to consider Dr. Garrett's report on the substantive causation issue. *Cf. Donna J. Calhoun*, 47 Van Natta 457, 458 n. 2 (1995) (Where there was no indication that an exhibit was offered or admitted solely for purposes of impeachment, the ALJ properly considered it as substantive evidence). Furthermore, even if we did, we would not find the report persuasive because we agree with the ALJ that it is not well-reasoned. Finally, we agree for the reasons the ALJ cited that the other medical evidence on which claimant relies does not satisfy her burden of proving a compensable injury.

ORDER

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

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[1] For a discussion of the uses for "impeachment" evidence, see the comments in Section 8 (footnote 9) of the Order of Adoption for Administrative Order 3-1997 (eff 3/1/98).

In the Matter of the Compensation of
LISA R. SHEPPARD, Claimant
WCB Case No. 97-04675
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's occupational disease claim for claimant's current neck condition; and (2) awarded an attorney fee of $7,500. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact,[1] with the exception of the "Notice Facts."

We summarize the facts as follows. Claimant, age 35, began working in chemical plants in 1986 and at the employer's plant in April 1990. The work was similar. Claimant's first job at the employer, which she held for two years, was a diamond operator. She cleaned cells used for making chemicals by high pressure washer. (Tr. I 17-24). The cells were very large and were moved with an overhead crane. (Tr. I 18). Later, claimant became a "B relief operator" in cell repair and utility, doing a variety of work throughout the plant. She worked on salt pads and loaded trucks and tank cars with chemicals. (Tr. I 24-53; Tr. II 57-103.

In early July 1996, claimant, who is right hand dominant, sought medical treatment for numbness in her right hand, cramping in her right arm, pain in her right shoulder and neck, and tingling in her left hand. (Exs. A, B). She was diagnosed with carpal tunnel syndrome and disc space narrowing and spondylosis at C5-6. (Exs. A, C).

On November 1, 1996, claimant sought treatment for pain in her neck, left shoulder and left arm. (Ex. 1; Tr. 10). Dr. Reichle found tenderness but no radicular symptoms. He diagnosed left rhomboid and arm strains. On November 20, 1996, claimant filed a claim for those conditions. (Exs. 4, 14). On December 11, 1996, Dr. Baskin reviewed an MRI that showed tendonitis in the supraspinatus tendon. He diagnosed impingement syndrome, tendonitis, left rotator cuff, left supraspinatus. (Ex. 11).

On January 27, 1997, Drs. Thomas Martens and Cathleen Farris examined claimant for the employer. They noted complaints of pain in the left neck and left shoulder. They opined that claimant had a left shoulder strain with mild impingement syndrome, improved. They related these conditions to claimant's employment by history. (Ex. 16). Dr. Reichle concurred. (Ex. 23).

On February 3, 1997, Dr. Baskin released claimant to regular work as of February 4, 1997. (Exs. 17, 18). Claimant returned to work for one day only. She used a pressure washer in the cell repair area. Her symptoms returned and she reported that she was unable to work. Dr. Baskin took her off work again on February 5, 1997. (Ex. 19). The employer accepted a disabling left shoulder strain with mild impingement syndrome. (Ex. 20).

On February 17, 1997, Dr. Baskin again diagnosed a left shoulder impingement syndrome and injected the subacromial space with a cortisone preparation. On March 3, 1997, Dr. Baskin noted that claimant's symptoms were persisting and referred her to Dr. Wilson for a second opinion. Dr. Wilson reported that claimant had numbness and tingling in both arms and hands. He opined that claimant's shoulder symptoms were mild and advised that she be released to work on a graduated basis. (Ex. 25).

On May 5, 1997, Dr. Clyde Farris, orthopedic surgeon, examined claimant for the employer. He diagnosed left shoulder bicipital and rotator cuff tendinitis, left elbow extensor tendinitis, and a cervical strain superimposed on preexisting degenerative disc disease in the neck with foraminal stenosis at C5-6 on the left. He also opined that her current symptoms were due to the preexisting degenerative condition and that the condition related to the compensable injury was medically stationary. (Ex. 27). Dr. Reichle concurred with Dr. Farris's opinion. (Ex. 28).

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[1] We note that claimant began working for the employer in 1990, not 1970.

On May 7, 1997, the employer issued a current condition denial on the basis that the accepted injury was no longer the major contributing cause of claimant's current condition. (Ex. 29). Claimant requested a hearing.

On June 6, 1997, Dr. Baskin declared claimant medically stationary and released her to regular work. He recommended that she see a neurologist. (Ex. 33).

On June 24, 1997, claimant was evaluated by Dr. Cline, neurologist, for complaints of pain in her neck and upper extremity. After tests, Dr. Cline diagnosed right carpal tunnel syndrome and effacement of the left lateral recess and foraminal narrowing at C5-6, due either to a disc bulge or osteophytic spurring. (Ex. 37). Dr. Mason, neurological surgeon, opined that claimant had C5-6 cervical nerve root irritability and carpal tunnel syndromes, especially on the right, secondary to her work activities. (Ex. 38).

On September 3, 1997, claimant was again examined by Dr. Clyde Farris, who diagnosed degenerative disc disease at C5-6 with foraminal stenosis on the left; bicipital and rotator cuff tendinitis, left shoulder; and carpal tunnel on the right. (Ex. 39).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant agreed that she was raising the issue of compensability with respect to the employer's current condition denial, specifically the compensability of her current C5-6 nerve root impingement as an occupational disease. The employer agreed with claimant's specification of issues.[2] (Tr. 13).

Relying on the opinions of Dr. Cline and Dr. Mason, the ALJ concluded that claimant had established that her work activities were the major contributing cause of her neck condition or the worsening of a preexisting neck condition. On review, the employer argues that claimant has failed to establish compensability of her C5-6 nerve impingement condition.

The employer asserts that claimant's degenerative disease at C5-6 is a "preexisting disease." The employer also contends that claimant's C5-6 nerve root compression resulted from the combined effects of genetic factors, natural aging, cigarette smoking, and daily living activities in addition to work activities. On this basis, the employer argues that claimant must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. *See* ORS 656.802(2)(b).

Claimant has a disc bulge, stenosis, spondylosis and nerve impingement at C5-6. (Exs. 27-7, 28, 36, 40, 41). Uncontested medical evidence establishes that she suffers from preexisting degenerative disease at C5-6. (Exs. C, 27, 39, 40). Under these circumstances, compensability of claimant's occupational disease claim presents a complex medical question that must be determined by expert medical opinion. *Allie v. SAIF*, 79 Or App 284 (1986); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985).

There are three expert medical opinions that address the cause of claimant's current C5-6 impingement syndrome. 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).

Based on an examination of claimant and a review of her medical records, the nature of her employment and the absence of off-work causative factors, Dr. Mason opined that claimant suffered from preexisting spondylosis at C5-6, which combined with claimant's work activities and resulted in a disc bulge that then caused nerve root irritation at C5-6. He opined that the mechanical forces of claimant's employment caused the nerve roots to be pulled back and forth through the nerve root canal, which irritated the nerve root, resulting in swelling of the nerve and further impingement, which was further exacerbated by the broad-based disc bulge. (Ex. 40).

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[2] Claimant suggested at hearing that the diagnosis of a left shoulder strain and shoulder impingement was not a complete diagnosis of her condition, as she had had C5-6 nerve root impingement in her neck in July 1996 that progressed until diagnosed by Dr. Cline in June 1997. (Tr. 14, Ex. C).

Dr. Cline opined that claimant suffered from a C5-6 nerve root impingement that resulted from a broad-based disc bulge, degenerative osteophytic spurring, or a combination of the two. She also stated that the disc bulge could be either the result of degeneration or of a discrete injury. She explained that she was unable to determine whether the disc bulge resulted from a discrete traumatic event or from the gradual wear and tear of claimant's work activities. In either event, Dr. Cline concluded that the major contributing cause of the disc bulge was claimant's work activities, based on the medical records provided to her. (Ex. 41).

Dr. Clyde Farris, who examined claimant on two different occasions for the employer, found that claimant had a cervical strain that was superimposed on preexisting degenerative disc disease of the cervical spine with foraminal stenosis at C5-6 on the left. He opined that a number of factors could have contributed to the stenosis and narrowing at C5-6, namely an injury, extreme neck posture over an extended period, age, genetics, and claimant's cigarette smoking, as well as her work activities. Dr. Farris further opined that, although claimant's work activities may have caused the preexisting degeneration and stenosis to become symptomatic from time to time, the work activities were not the major contributing cause of her condition or the pathology in her neck. (Ex. 42-21, 42-24 through 42-27). Dr. Farris supported his opinion by his findings of no clinical neurological deficits, such as loss of strength, muscular atrophy, or non-symmetrical reflexes. (Ex. 42-39, -40).

We are not persuaded by either Dr. Mason's or Dr. Klein's opinion. Although Dr. Mason explains the mechanics by which claimant's nerve root is affected, he does not evaluate the relative contributions of all the factors that may be contributory (her age, genetics, cigarette smoking, the herniated disc, the preexisting condition, and her work activities) to claimant's current need for treatment, as required under *Dietz v. Ramuda*, 130 Or App 397, 401 (1994). Dr. Klein states that claimant's condition results from either a broad-based disc bulge, degenerative osteophytic spurring, or both; she also indicates that the disc bulge may be the result of degeneration or an injury, or the wear and tear of claimant's work activities. Finally, she opines that the major contributing cause of the disc bulge *is* claimant's work activities without explaining her rationale for doing so. Moreover, like Dr. Mason, she did not evaluate the relative contributions of all the contributory factors to claimant's condition and need for treatment. Thus, although the medical reports establish that claimant currently suffers from C5-6 nerve root impingement, the medical opinions supporting compensability do not persuade us that the major contributing cause of claimant's current condition and need for treatment is her work activities, particularly given the multiple factors (as noted by Dr. Clyde Farris) that may contribute to her condition.[3]

Because we do not find claimant's current condition to be compensable, we do not address the employer's objections to the ALJ's award of attorney fees.

ORDER

The ALJ's order dated June 26, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[3] On review, the employer contends that the opinions provided by Dr. Mason and Dr. Cline are not persuasive because they are no more than "check the box" opinions. We do not agree with the employer's contention. *Roseburg Forest Products v. Glenn*, 155 Or App 318 (1998) (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).

In the Matter of the Compensation of
DARYL L. UNDERWOOD, Claimant
WCB Case No. 98-04106
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by the Board *en banc*.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that awarded claimant's attorney an assessed fee of $3,000 for services at hearing. On review, the issue is attorney fees.

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

Claimant's attorney is entitled to a reasonable assessed fee for services provided at hearing in prevailing over SAIF's denial of claimant's low back injury claim. ORS 656.386(1). Neither party submitted any argument to the ALJ as to how the factors in OAR 438-015-0010(4)[1] should be weighed in determining a reasonable fee. Furthermore, claimant's attorney did not submit a statement of services or make any specific attorney fee request regarding services provided related to the compensability issue. The ALJ awarded claimant's attorney an assessed fee of $3,000 for services at hearing in setting aside SAIF's denial. However, the ALJ did not indicate that he had considered the factors in OAR 438-015-0010(4) in determining that fee.

On review, SAIF requests that we remand the case 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), and *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998). SAIF does not argue that the $3,000 fee awarded by the ALJ is excessive, nor does it make any specific arguments regarding the factors provided by OAR 438-015-0010(4). Instead, SAIF argues that, when the reasoning in *Schoch* and *McCarthy* is applied to OAR 438-015-0010(4), the Board (or an ALJ) is *required* to take the following steps to comply with the requirements of the administrative rule: (1) make findings of fact under *each* of the eight factors in OAR 438-015-0010(4); (2) draw conclusions from those specific findings of fact; and (3) then demonstrate how those conclusions should be weighed in determining a reasonable attorney fee. We disagree.

In *Russell L. Martin*, 50 Van Natta 313 (1998), we rejected a similar argument and determined that *Schoch* was distinguishable on its facts. 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. We concluded that it was enough for the ALJ to state that the rule-based factors had been considered, with particular emphasis on certain factors, in reaching a decision regarding the amount of a reasonable fee. Thus, we found that the ALJ's explanation for the fee award was sufficient compliance with the *Schoch* Court's instruction to provide a rational connection betweenconsideration of the rule-based factors and the amount of the fee awarded. *See also Carrie Newton*, 50 Van Natta 1750 (1998); *Sherlie A. Dial*, 50 Van Natta 1405 (1998); *Deborah F. Morgan*, 50 Van Natta 1374 (1998).

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

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

Moreover, our conclusion in *Martin* is supported by the Court's reconsideration of its decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or at 188-89. In *McCarthy*, the Court of Appeals, without explanation, awarded attorney fees to the prevailing defendant in a civil case. On review, the Supreme Court noted that ORS 659.121(2) authorized the court to award the prevailing party costs and reasonable attorney fees and ORS 20.075[2] provided the factors that the court must consider in deciding whether and to what extent to award attorney fees under ORS 659.121(2). 327 Or 91-92. Because the Court of Appeals offered no explanation for its attorney fee award, the Court remanded the case to the Court of Appeals for further proceedings.

In reaching this decision, the Court stated:

> "[A]s a practical matter, this court cannot analyze the record to determine whether a court's decision to award or deny an attorney fee pursuant to statute was an abuse of discretion unless the court, in its findings, identifies the relevant facts and legal criteria on which the court relies in awarding attorney fees." *Id.* at 96.

SAIF quoted the above statement in support of its argument that an ALJ or the Board must make findings of fact under *each* of the eight factors under OAR 438-015-0010(4) in order to comply with the rule and create a reviewable order under *Schoch*. However, the Court rejected such an interpretation of its opinion when it clarified its decision on reconsideration.

On its own motion, the Court reconsidered its decision in order to clarify the Court of Appeals' task on remand. 327 Or 185. The Court stated that a court need not address facts and legal criteria that are not material to its decision, explaining that

> "[a] court would satisfy its obligation to make findings in a case involving ORS 20.075 by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees. The court would have no obligation to make findings on other statutory criteria that play no role in the court's decision." *Id.* at 188 (footnote omitted).

The Court also stated that "[n]o party will be heard to complain of the absence of a finding by the court on an issue that the party did not raise. . . ." *Id.* at 189. However, where a party does make objections, the court need only address the objection or objections that are material to its decision, it "need not make findings about the validity of other objections that play no role in its decision." *Id.*

We note that ORS 20.075, the statute the Court applied in *McCarthy*, and OAR 438-015-0010(4), the applicable rule in the present case, contain the same relevant language, *i.e.*, that the court, the ALJ, or the Board "shall consider" certain enumerated factors in determining an attorney fee award. Nevertheless, the Court did not hold that this "shall consider" language in ORS 20.075 required that the court explicitly address each of the factors enumerated in that statute. The same reasoning applies to OAR 438-015-0010(4).

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[2] ORS 20.075 provides, in part:

"(1) A court shall consider the following factors in determining whether to award attorney fees in any case in which attorney fees are authorized by statute and in which the court has discretion to decide whether to award attorney fees:

"* * * * *[The statute proceeds to list eight separate factors: (a) through (h)].

"(2) A court shall consider the factors specified in subsection (1) of this section in determining the amount of an award of attorney fees in any case in which attorney fees are authorized by statute and in which the court has discretion to decide whether to award attorney fees. In addition, the court shall consider the following factors in determining the amount of an award of attorney fees in those cases:

"* * * * * [The statute proceeds to list eight separate factors: (a) through (h)].

"(3) In any appeal from the award or denial of an attorney fee subject to this section, the court reviewing the award may not modify the decision of the court in making or denying an award, or the decision of the court as to the amount of the award, except upon a finding of an abuse of discretion."

Thus, the Court's decision in *McCarthy* supports our holding in *Martin* that an ALJ is not obligated to make specific findings regarding the rule-based factors in a case where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Pursuant to the reasoning in *McCarthy* and *Martin*, under such circumstances, it is sufficient for the ALJ to describe or cite the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded.

Having determined the proper standard an ALJ must use in determining a reasonable attorney fee under OAR 438-015-0010(4), we turn to the facts of the current case. Here, the ALJ simply ordered SAIF to pay "to claimant's counsel $3,000 as and for a carrier-paid fee for his efforts in this matter." Thus, because the ALJ did not indicate that he applied the rule-based factors in determining the attorney fee, we find the ALJ's reasoning insufficient to determine how he arrived at $3,000 as a reasonable attorney fee.

Nevertheless, 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 is not necessary 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 and proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing.

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 one hour and 15 minutes; claimant and an employer witness testified. The record consists of 37 exhibits, four of which were submitted by claimant's attorney. Claimant's attorney obtained a medical report from claimant's treating physician that was favorable to claimant's position.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average complexity regarding the legal and factual issues involved. However, given claimant's preexisting low back condition, the medical issues were of above-average complexity. The value of the interest and benefit secured were significant, in that claimant has obtained benefits for his L4-5 disc herniation that will require surgery to repair. Both attorneys are skilled litigators with substantial experience in workers' compensation law. Moreover, considering the conflicting medical opinions, there was a risk that claimant's attorney might go uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services at hearing is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Furthermore, as discussed above, 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).[3]

ORDER

The ALJ's order dated September 4, 1998 is affirmed.

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[3] Although claimant initially submitted a Statement of Services, he has subsequently withdrawn it in light of the *Dotson* holding. Consequently, neither the Statement of Services nor SAIF's response to the Statement of Services have been considered.

In the Matter of the Compensation of
MARK A. BAKER, Claimant
WCB Case No. 98-00933
ORDER ON REVIEW
Swanson, Thomas, et al, Claimant Attorney
David L. Jorling, Defense Attorney

Reviewed by the Board *en banc.*

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that awarded a $3,000 attorney fee pursuant to ORS 656.386(1)(b)(B) when the employer accepted claimant's insomnia with sleep apnea and bilateral hearing loss conditions after claimant's written request for acceptance of those conditions. We reverse.

FINDINGS OF FACT

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

Claimant sustained a compensable electrical shock injury on January 23, 1996. He was treated at an emergency room for left arm pain and filed a workers' compensation claim on January 25, 1996.

Dr. Bell treated claimant for pain in the left arm and leg with jerking in both arms. Dr. Bell believed that claimant had sustained an electrical injury of the left arm with probable damage to the nerves and sympathetic nervous system.

On April 16, 1996, the employer accepted the claim as a disabling burn of the left hand and wrist.

Claimant's complaints expanded over the next two years. Dr. Bell suspected a significant frontal lobe deficit. He referred claimant to Dr. Stanulis, who observed physical, psychological and neuropsychological deficits manifesting themselves as headache, left arm pain, balance difficulties and problems with the initiation of behavior and executive functioning.

A brain SPECT showed mild to moderate diffuse abnormalities involving the temporal and parietal lobes including significant decrease in thalamic activity on the left.

The conditions for which Dr. Bell was treating claimant continued to expand to include cervical strain syndrome, status post-electrical injury with radicular complaints left arm and shoulder, cognitive dysfunction and possible sympathetic nerve damage. On March 26, 1997, Dr. Bell identified headache, persistent dizziness, left hip and knee pain, left ankle pain, left arm pain, spots in front of the eyes with dizziness and nausea, chronic fatigue, heart palpitations, fluctuating blood pressure, sleeping problems, decreased hearing, poor appetite and impotence.

Claimant was seen by Dr. Hodgson, who diagnosed vestibular injury resulting in permanent impairment.

Dr. Bell declared claimant stationary on June 30, 1997. Dr. Stanulis also considered claimant stationary, but felt claimant was permanently and totally disabled as a result of severe brain injury resulting in behavioral, cognitive and emotional difficulties.

On November 19, 1997, the employer wrote to Dr. Bell to identify those conditions that should be acknowledged as compensable on its "pre-closure" Notice of Acceptance. As a result of that correspondence, the conditions identified included electrocution featuring intracranial brain injury, non-psychotic mental disorder, visual field defects, causalgia including mononeuritis of the left arm and hand and left traumatic vestibular neuronitis.

Claimant's counsel wrote to the employer on December 8, 1997 requesting that the employer accept depression, sexual dysfunction, bowel and bladder dysfunction, sleep disorder, headache, visual disorder, hearing loss, vestibular disorder, brain damage, loss of muscle strength and sensory loss. Claimant's attorney's letter also requested that the April 16, 1996 Notice of Acceptance be amended to include the additional conditions.

The employer acknowledged the request on January 2, 1998. That same day, the employer issued an amended Notice of Acceptance identifying the accepted conditions as: burn of the left hand/wrist, electrocution and nonfatal effects of electric current, shock from electric current featuring: intracranial injury, nonpsychotic mental disorder, causalgia/mononeuritis of left upper limb and mononeuritis complex of the left arm and hand of 1/23/96 and left traumatic vestibular neuronitis.

The employer, on January 5, 1998, contacted Dr. Bell concerning the conditions identified in claimant's counsel's December 8, 1997 letter. The employer did not specifically ask about the conditions of depression, visual disorder, hearing loss, vestibular disorder, brain damage, loss of muscle strength or sensory loss, stating that these conditions were already accepted. The employer did request Dr. Bell's opinion concerning the conditions of sexual dysfunction, bowel and bladder dysfunction, sleep disorder and headaches.

On January 14, 1998, Dr. Bell stated that it was reasonable to consider the headache and sexual dysfunction conditions as part of the non-psychotic mental disorder diagnosis. He could not confirm a bowel and bladder problem, but did consider the insomnia with sleep apnea a direct result of the electrocution. On January 16, 1998, the employer issued an updated Notice of Acceptance adding the condition of insomnia with sleep apnea.

On January 31, 1998, claimant filed a Request for Hearing alleging *de facto* denial of depression, sexual dysfunction, bowel/bladder disorder, headache, hearing loss, vestibular disorder, loss of muscle strength and sensory loss.

On March 9, 1998, the employer issued another amended Notice of Acceptance adding bilateral hearing loss, but deleting insomnia with sleep apnea.

Responding to a request for information from claimant's attorney, Dr. Bell, on April 2, 1998, identified the accepted diagnosis of causalgia, mononeuritis complex to be as accurate a diagnosis of claimant's left and right side physical defects as could be drawn. Dr. Bell acknowledged that claimant still had bowel, bladder and sexual dysfunction.

At hearing, the parties stipulated that the employer has paid all compensation benefits due, including time loss. The parties further stipulated that the sexual dysfunction component was an accepted part of the claim and was included within the conditions previously accepted.

The conditions of insomnia with sleep apnea and bilateral hearing loss were accepted more than 30 days after receipt of claimant's attorney's December 8, 1997 letter requesting acceptance of the additional conditions, but less than 90 days from the receipt of that letter.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's attorney's December 8, 1997 letter asking for acceptance of the additional conditions was an objection to the employer's Notice of Acceptance under ORS 656.262(6)(d) for which the employer had 30 days to respond, rather than a claim for new medical conditions under ORS 656.262(7)(a), that the employer would have had 90 days to accept or deny.[1] On this basis, the ALJ found that claimant was entitled to an attorney fee pursuant to ORS 656.386(1)(b)(B) for prevailing over a denied claim because the employer had not responded to claimant's request for modification of the Notice of Acceptance within 30 days.

On Board review, the employer argues that claimant's attorney's December 8, 1997 letter was a claim for new medical conditions pursuant to ORS 656.262(7)(a), and because the claim was processed and the conditions accepted within 90 days, no attorney fee may be awarded pursuant to ORS

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[1] The ALJ relied on *Teresa Kersey-Sherbina*, 49 Van Natta 563, *on recon* 49 Van Natta 639 (1997), in concluding that the December 8, 1997 communication from claimant was an objection to the Notice of Acceptance under ORS 656.262(6)(d). We do not find our holding in *Kersey-Sherbina* to be helpful here. In *Kersey-Sherbina*, we held that a denial was a legally appropriate response to an objection to a Notice of Acceptance. There was no issue in *Kersey-Sherbina* concerning whether the claimant's communication was an objection to the acceptance notice or a new medical condition claim.

656.386(1)(b)(B).[2] More specifically, the employer argues that in order for the 30-day time limit in ORS 656.262(6)(d) to apply, the diagnoses must have been claimed at the time of the notice of acceptance and a claimant's communication to the carrier must state that it is an objection based on an omission or deficiency in the notice of acceptance. On this basis, the employer argues that claimant's communication is a notice of a claim for a new medical condition under ORS 656.262(7)(a) rather than an objection to the acceptance notice.

Claimant argues that the conditions that his attorney requested be accepted on December 8, 1997 were not new and had been diagnosed for at least a year. On this basis, claimant argues that the December 8, 1997 letter was a request for modification of the Notice of Acceptance rather than a new medical condition claim.

In order to determine their meaning, we examine the text of the statutes in context, turning to the 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 (1993).

ORS 656.262(6)(d) provides:

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

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 any new medical condition from the insurer or self-insured employer."

ORS 656.262(6)(d) refers to a condition that has been incorrectly *omitted* from a notice of acceptance while ORS 656.262(7)(a) refers to claims for aggravation or *new* medical conditions *after* claim acceptance. The words "new," "omitted" and "after" are terms of common usage and should be given their "plain, natural, and ordinary meaning."[3] *See PGE*, 317 Or at 611. The word "new" means having existed or having been made but a short time, having originated or occurred lately, not early or long in being. "After" means following in time or place. Webster's Third New Int'l Dictionary 1522, 1574 (unabridged ed. 1993). "Omit" means to leave out or leave unmentioned.[4]

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[2] ORS 656.386(1)(a) provides for an assessed attorney fee in cases involving denied claims where the claimant prevails finally in a hearing before an ALJ. ORS 656.386(1)(b)(B) provides:

> "(b) for purposes of this section, a "denied claim" is:
>
> "* * * * *
>
> "(B) 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."

[3] These terms are not defined in the workers' compensation statutes.

[4] Webster's Third New Int'l Dictionary 38, (unabridged ed. 1993).

Based on the text and context of the statute, including the plain, natural and ordinary meaning of the relevant terms, we find that a new medical condition under ORS 656.262(7)(a) is one that comes into being following the issuance of the Notice of Acceptance. In this regard, the statute says "after claim acceptance," written notice of acceptance or denial of claims for "new" medical conditions shall be furnished to the claimant within 90 days. This language strongly supports the conclusion that a "new" medical condition is one that comes into being after the Notice of Acceptance.

We further find that a condition that is incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is a condition that is in existence at the time of the notice, but is not mentioned in the notice or is left out.[5] This interpretation is consistent with the statute's reference to a worker's

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[5] ORS 656.262(6)(d) and 656.262(7)(a) were enacted in 1995 as part of Senate Bill 369. Although it is unnecessary for us to examine the legislative history since we do not find the language of the statutes to be ambiguous, we note that the legislative history of Senate Bill 369 supports our interpretation of the statutes. Statements made by Representative Mannix in explaining the statutes make it clear that ORS 656.262(6)(d) was designed for situations where the worker believed a condition was "left out" of a Notice of Acceptance. Similarly, it is apparent from the legislative history that "new" conditions are conditions that come into being later in the claim after acceptance:

> " * * * send out this notice of acceptance and if the worker thinks something was left out, the worker should write a letter to the employer/insurer and say you left this out of my claim. Then they have 30 days to respond. And in most instances, in my opinion, they're going to respond by saying, oops, you're right, or let's clarify this, let's get to it. But that you don't just plop down and file a request for hearing. You have to go through this process to allow them an opportunity to correct the alleged error. And if they correct it, fine. If they don't, then you can litigate it. That is designed to, again, allow for a straightforward communication, where's the beef, try to get it clarified. If they refuse to clarify, then you can take it to hearing.
>
> "This also sets some standards for how you present your notice of acceptance or denial of claims for aggravation time frame of 90 days after you get written notice of the claim. It also makes it clear that if you're trying to bring up a new medical condition, something that didn't occur in your claim before, there is a process here now that you ask for written acceptance. Write a letter. The reality of free flow is you want employers and insurers to get the bill and pay the bill and take care of it, but we have created a system where they are so nervous now that if they issue a notice of acceptance and it doesn't cover everything, that they have to issue a denial of this, that or the other. We want a free flow of communication where if the worker thinks enough wasn't covered, write a letter. Now, if they aren't going to cover it, they're going to be stuck with denying it, but it's going to require communication. And if something new comes up on the claim later on, write a letter and say I want this included in my claim. But the problem right now is that there may be a bill that comes in with a diagnostic label on it and that's now treated as a new claim. Nobody notices it, and they may even pay the bill, but they didn't issue a notice of acceptance. Well, if somebody wants a notice of acceptance after the claim is accepted, and they think there's a new condition, they can write a letter. If the bill isn't paid, by the way, without the issuance of a denial, they can still litigate that. Hey, you refused to pay this bill that you got on my claim. But we're trying to reduce litigation here and just smooth the flow of information." (House Labor Committee Hearing - March 6, 1995, Tape 46A) (Emphasis added).

Representative Mannix also explained these statutory provisions in January 1995 meeting of the Senate Labor and Goverment Operations Committee:

> "656.262, sub (6)(d): Establishes a procedure to verify scope of acceptance. In 1990, as part of the reforms, we required employers and insurers to give a written statement to the worker, telling the worker what condition was accepted. We have now discovered a catch 22, when you tell the worker you have accepted the claim; you sent out that written notice, you describe the condition, the catch 22 is now the attorneys are saying, oh, implicitly, because you didn't list something else, you have denied that condition, even though you didn't issue a letter of denial; even though you paid the medical bills; even though you paid the time loss; you paid the permanent disability; somehow you have done a de facto denial, Latin for a denial as a matter of fact rather than as a matter of law, and got you; you've done something wrong; you got caught. Well, wait a minute. This says, if you want to say that there is a condition that was properly part of the claim and it wasn't accepted, write a letter to the employer or insurer, tell them that, hey, you overlooked this. They have 30 days to respond and if they don't provide you with a clarification of acceptance, then you can challenge. But it requires that they be given an opportunity to (inaudible). For example, if you have a low back strain, most people would assume that includes a lumbosacral strain. But maybe the doctor, at some point, also included the lower thoracic area. Someone would argue that you did not accept the lower thoracic area, even though you accepted lower back strain; you may have

"objection" to the notice and the reference to a condition that is "incorrectly omitted" from the acceptance or a notice that is "otherwise deficient." This language supports the conclusion that the statute pertains to a condition(s) that is already in existence at the time of the notice, but is left out or omitted from the notice.

As further support for this interpretation, we note that the legislature enacted separate statutes and procedures for new medical condition claims and objections to notices of acceptance and gave different time lines for the processing of each type of claim. Thus, the legislature intended a distinction between the two types of claims. Based on the text and context of the statute, including the plain, natural and ordinary meaning of the relevant terms, we find that it was the legislature's intent that new medical condition claims are distinguished from claims omitted from a Notice of Acceptance in that they are claims for conditions that are "new" or that did not come into being until after the Notice of Acceptance.

Finally, the use of the same 90 day processing time limit for both new medical condition claims and initial claims under ORS 656.262(6)(a) suggests that the legislature viewed a "new medical condition" claim as similar to an initial injury claim and wanted to give the same time line for processing both types of "new" claims. The similar processing of new medical condition and initial claims for new injuries/occupational diseases suggests that the legislature considered new medical condition claims to be similar to initial claims in that the condition (or injury/disease) is new and warrants more time to process and investigate than an objection to a Notice of Acceptance on the basis that a condition already existing at the time of the notice has been omitted.

In the present case, the only conditions apparently accepted as a result of claimant's attorney's December 8, 1997 letter were insomnia with sleep apnea and bilateral hearing loss. The employer agreed that all of the other claimed conditions were contained within the diagnosed conditions that were already accepted. Based on the record, both the insomnia with sleep apnea and bilateral hearing loss conditions came into being after the April 16, 1996 Notice of Acceptance. Hearing problems were first noted in Dr. Erb's August 14, 1996 evaluation, which was after the April 16, 1996 Notice of Acceptance. Some trouble sleeping was reported soon after the Notice of Acceptance; however, the sleep apnea condition was not diagnosed until early 1997. Under such circumstances, the record does not establish that the conditions were in existence or had come into being at the time of the Notice of Acceptance and were omitted. On this basis, we find that claimant's attorney's December 8, 1997 letter was a claim for new medical conditions pursuant to ORS 656.262(7)(a) and was not a request that the Notice of Acceptance be modified to accept an omitted condition.[6]

Applying ORS 656.262(7)(a) to the facts of this case, claimant's attorney's December 8, 1997 letter clearly requested acceptance of the sleep apnea and hearing loss conditions and was a claim for a new medical condition under the statute. The conditions were "new" because they did not come into being until after the Notice of Acceptance. The new conditions were accepted and notice was furnished to claimant within 90 days of the claim. Because the new conditions were processed within 90 days in compliance with ORS 656.262(7)(a), there was no denied claim and, therefore, no attorney fee may be awarded under ORS 656.386(1)(b)(B). Accordingly, the attorney fee award is reversed.

ORDER

The ALJ's order dated May 21, 1998 is reversed.

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paid all the bills; you may have paid all the benefits, but, gotcha! Now we are going to get an attorney fee and maybe a penalty out of you because you did not issue the right notice of acceptance. This just says, send a letter and explain that you wanted something else covered and that will clarify the situation.

"ORS 656.262, sub (7): This establishes a procedure for consideration of new conditions. Now, it is important to point out that you can bring in aggravation claims, you may have ongoing conditions, what if you think that you have a new condition that was not covered at the time of acceptance. Well, we need a procedure for that. This sets it up and it allows the worker to present that new condition for processing by the insurer." (Senate Labor and Govt. Operations Committee meeting jointly with House Labor Committee - January 30, 1995, Tape 15B) (Emphasis added).

[6] Even if the December 8, 1997 letter was intended by claimant's counsel as an objection to the Notice of Acceptance, the letter did not qualify as an objection under ORS 656.262(6)(d) insofar as the insomnia with sleep apnea and hearing loss conditions are concerned because those conditions came into existence after the Notice of Acceptance.

In the Matter of the Compensation of
MARY CORONAS-ROSSMAN, Claimant
WCB Case No. 98-03185
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration that awarded no scheduled permanent disability for claimant's left knee injury. On review, the issue is scheduled permanent disability.

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

The ALJ determined that claimant's compensable August 8, 1996 left knee injury did not result in permanent impairment. In making this determination, the ALJ relied on the medical opinion of an examining physician, Dr. Thompson, who opined that, after claim closure, claimant's injury did not materially contribute to her left knee condition, and with whose opinion the attending physician, Dr. Thomas, concurred.

On review, claimant contends that the ALJ should have deferred to the opinion of the medical arbiter, Dr. Berselli, who attributed 20 percent of claimant's "restrictions and limitations" to the accepted left knee condition.[1] Claimant argues that Dr. Berselli's opinion is more persuasive primarily because it was conducted approximately 6 weeks before the reconsideration order, whereas Dr. Thompson's examination occurred 6 months prior to the order. As support, Claimant cites *Kelly J. Zanni*, 50 Van Natta 1188 (1998), in which we concluded that the findings of a medical arbiter made less than 3 weeks prior to a reconsideration order were more persuasive than attending physician-ratified muscle strength findings made 5 months prior to the reconsideration order.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter(s), if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). The impairment findings of an independent medical examiner may be used only when the attending physician has ratified those findings. *Owen*, 129 Or App at 445. Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well- reasoned evaluation of impairment due to the injury/disease. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *See, e.g., Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *E.g., James A. Hanson*, 50 Van Natta 23, 24 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996); *David Gonzalez*, 48 Van Natta 376 (1996).

In this case, we acknowledge that there was a significant time gap between Dr. Thompson's examination and the reconsideration order. Unlike *Zanni*, however, where the issue was whether the claimant had ratable muscle strength impairment (causation was not at issue), the issue here is whether claimant has impairment attributable to the compensable injury. Thus, we are inclined to agree with the insurer that the issue in this case is more a matter of analysis, rather than observation or measurement in close proximity to a reconsideration order. Therefore, we do not find the time gap between Dr. Thompson's examination and the reconsideration order dispositive in deciding which report, Dr. Thompson's or the medical arbiter's, is more persuasive. Moreover, we agree with the ALJ's reasons for finding Dr. Thompson's opinion more persuasive.

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[1] The parties stipulated that, if the medical arbiter's report was deferred to, it would entitle claimant to 4 percent scheduled permanent disability.

Accordingly, we conclude that claimant does not have permanent impairment attributable to the compensable injury. We, therefore, affirm.[2]

ORDER

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

[2] The insurer argues, alternatively, that, even if Dr. Berselli's opinion were more persuasive, it would still not entitle claimant to scheduled permanent disability. Given our disposition of the case, we need not address this issue. We note, however, that this argument appears inconsistent with the stipulation of the parties.

December 14, 1998 Cite as 50 Van Natta 2339 (1998)

In the Matter of the Compensation of
GERALD W. HANNAH, Claimant
WCB Case No. 94-0699M
OWN MOTION ORDER ON RECONSIDERATION
Roger Wallingford, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

We issued an Own Motion Order on January 10, 1995, as corrected on January 19, 1995, which declined to reopen claimant's claim for the payment of temporary disability compensation because he failed to establish that his current condition required surgery or hospitalization. Thereafter, we withdrew our orders to consider claimant's contention that his current condition required surgery or hospitalization.

The insurer denied responsibility for claimant's current left elbow/epicondylitis, posterior interosseous nerve condition on January 4, 1995. Claimant requested a hearing with the Hearings Division regarding that denial. (WCB Case Nos. 95-02771 and 95-02772). Inasmuch as claimant had requested a hearing on related matters, on March 31, 1995, we consolidated the own motion matter with the pending litigation. At the hearing, if claimant's current condition was found to be the responsibility of the own motion insurer, we requested the assigned Administrative Law Judge (ALJ) to take evidence regarding whether claimant's current condition had worsened requiring surgery and/or hospitalization and whether claimant was in the work force at the time his condition worsened.

By Opinion and Order dated October 21, 1998, ALJ Kekauoha found the own motion insurer responsible for claimant's current left elbow condition. That order was not appealed and has become final by operation of law.

Concurrent with the issuance of his Opinion and Order, ALJ Kekauoha submitted his Own Motion Recommendation, concluding that: (1) there was no persuasive evidence to establish that claimant's accepted left elbow condition requires surgery or hospitalization; and (2) even if claimant's condition had worsened requiring surgery or hospitalization, he would not be entitled to temporary disability compensation because of his incarceration for the commission of a crime. *See* ORS 656.160.

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.

Although the own motion insurer was found responsible for claimant's current condition, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment. 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.*

IT IS SO ORDERED.

[1] Inasmuch as we have determined that we are not authorized to grant claimant's request to reopen his claim because the record fails to demonstrate that his current condition requires surgery and/or hospitalization, we need not address the work force issue.

In the Matter of the Compensation of
JEFFREY E. HENDERSON, Claimant
WCB Case Nos. 97-08508 & 97-08507
ORDER ON REVIEW
Lane, Powell, et al, Defense Attorneys

Reviewed by the Board *en banc.*

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Davis' order that found his claims for a right groin injury and left shoulder injury were time-barred under ORS 656.265(4). On review, the issue is timeliness of the claims and, in the event the claims are timely, compensability. We affirm.

FINDINGS OF FACT

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

Claimant, age 34 at the time of hearing, worked for a newspaper publishing company. Between January 1996 and July 1997, claimant's job involved preparing newspapers for delivery and delivering papers in his own car to about 350 subscribers within a 12-mile radius. Most of the distribution involved placing the papers into tube receptacles, although he did throw bagged papers onto the porches of 30 to 40 subscribers.

In approximately August 1996, claimant noted problems with his shoulder. He felt a pulling sensation as he threw papers, and began to be more careful with his arm.

On or about March 9, 1997, while seated in his car and delivering papers, claimant noticed a burning sensation in the right side of his groin as he reached over to pick up newspapers from the passenger side floor. In the months that followed, he experienced intermittent symptoms in his groin as well as both shoulders. Claimant did not seek treatment, however, hoping that his symptoms would resolve in time.

On July 28, 1997, just prior to terminating his employment, claimant completed an 801 form for a lower abdomen strain, in which he described the March 9, 1997 incident. Claimant also made a claim for pain in his left shoulder, alleging an October 1996 date of injury.

On July 30, 1997, claimant was examined by Dr. Cooper. Claimant apprised Dr. Cooper of the March 9 incident and burning sensations in his groin as well as the soreness in his left shoulder. Dr. Cooper found no evidence of right inguinal herniation, but intermittent tenderness to palpation in claimant's right groin area. With regard to the left shoulder, Dr. Cooper found full, comfortable range of motion, no tenderness and no evidence of a rotator cuff tear. He did not authorize time loss nor recommend any follow up treatment.

On September 16, 1997, the insurer denied the compensability of claimant's left shoulder and right groin pain. The denial also challenged the timeliness of claimant's claims, asserting that the employer did not have notice within 90 days.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer sought dismissal of claimant's request for hearing, arguing that the claims were untimely under ORS 656.265. Alternatively, the insurer asserted that claimant had not established the compensability of his alleged injuries under ORS 656.005(7). The ALJ agreed, finding that the claims had not been timely filed and that, even if timely, the record did not show the claimed injuries required medical service or resulted in disability.

On review, claimant argues that his groin claim was timely under ORS 656.265(4)(a) because the employer had notice of his injuries within one year and, in any event, the insurer waived the timeliness defense by not raising the issue at the outset of hearing.[1] Claimant also argues that, on the merits, he has established the compensablity of a groin injury. We find to the contrary.

[1] Claimant does not specifically address his left shoulder claim on review.

As a preliminary matter, we find that the insurer has not waived the timeliness defense. As noted above, the insurer specifically asserted that claimant did not provide timely notice in its September 16, 1997 denial. Furthermore, in his opening statement at hearing, the insurer's counsel requested dismissal on the grounds claimant did not provide notice within 90 days. (Tr. 19-20).

We also find that claimant's groin claim is properly analyzed as an injury, and therefore ORS 656.265 is the applicable limitations statute. When the symptoms occur over a discrete, identifiable period of time, are unexpected and due to a specific activity or event, the condition is properly analyzed as a injury. *See, e.g., James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982). Here, claimant contends that his groin injury arose from a specific incident, when he reached over to transfer papers from the floorboard to the passenger seat. Therefore, his claim stems from an injurious event, rather than an ongoing state or condition of the body.

ORS 656.265 provides, in pertinent part, as follows:

> "(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer, but not later than 90 days after the accident. * * *
>
> "* * * * *
>
> "(4) Failure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the accident and:
>
> "(a) The employer had knowledge of the injury or death[.]"

After reviewing the record, we find no evidence that the employer had notice of claimant's alleged groin injury (or any accident or incident involving claimant's groin area) within 90 days. Rather, the insurer's assertion that the employer was not given notice of the claim until July 25, 1997 (138 days after the alleged injury date) is uncontroverted. (*See* Exs. 5, 6). Because claimant did not give notice of the accident within 90 days, he did not comply with ORS 656.265(1). But, insofar as he gave notice of the claim within one year, we must determine whether the claim can go forward under subsection 4(a).

When interpreting a statute, our task is to discern the legislature's intent. This task begins with an examination of the text and context of the statutory provision. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). Text and context includes prior judicial interpretation of the statute. *See State v. King*, 316 Or 437, 445-46 (1993) (when the Supreme Court interprets a statute, that interpretation becomes part of the statute as if written into it at the time of its enactment). If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *PGE*, 317 Or at 611.

Where the intent of the legislature is not clear after an examination of the text and context of the statute, however, we consider the legislative history of the statute. *Id.* at 611-12. Finally, if there exists no legislative history that sheds light on the issue, we will resort to general maxims of statutory construction, including the maxim that where no legislative history exists, we will attempt to determine what the legislature would have done, had it considered the issue. *See Westwood Homeowners Assn., Inc. v. Lane County*, 318 Or 146, 158 (1993) (citing *PGE*, 317 Or at 612), *adhered to as modified* 318 Or 327 (1994).

According to ORS 656.265(4)(a), if notice is given within one year after the date of the accident, the claim is not barred when the "employer had knowledge of the injury or death." This provision does not, however, provide a specific time period within which the employer must have had such knowledge.[2]

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[2] In *Argonaut Insurance v. Mock*, 95 Or App 1 (1989), the court discussed what constitutes "knowledge of the injury" for purposes of ORS 656.265(4)(a):

> "'[K]nowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate." *Id.* at 5.

After considering the text and context of ORS 656.265, we conclude that the legislature intended that the employer must have had knowledge of the injury within 90 days of the accident for the claim not to be barred. Subsection (1) provides, in clear terms, that notice of an accident resulting in injury "shall be given immediately * * * to the employer, but not later than 90 days after the accident." Subsections (2) and (3) set forth the specific requirements for giving this notice to the employer, and provide that if for any reason it is not possible to so notify the employer, notice may be given to the Director of the Department of Consumer and Business Services. Subsection (4) provides that the claim is to be barred for failure to give the required notice, unless the notice is given within one year of the accident *and* the "employer had knowledge of the injury or death[.]"

To construe subsection (4) as allowing a claim made within one year of the accident to go forward so long as the employer has knowledge of the injury or death within that year renders the 90 day notice requirement set forth in ORS 656.265(1) essentially meaningless. Moreover, such an approach would be contrary to ORS 174.010, which requires us to adopt, if possible, a construction that will give effect to all provisions of a statute. *See Northwest Alliance for Mkt. Equality v. Dept. of Revenue*, 318 Or 129, 133 (1993). To give effect to both the 90 day requirement of subsection (1) and the exception/extension set forth in subsection (4), the statute must be read to require that the employer have "knowledge" of the injury (but not necessarily notice of the claim) within 90 days of the accident.

Furthermore, recognizing that words of common usage should be given their plain, natural, and ordinary meaning,[3] we note that the words "had knowledge" in subsection (4)(a) indicates the past tense, as in requiring that the employer be aware of the injury at a point in time prior to receiving notice of the claim. Consequently, we construe ORS 656.265(1) and (4)(a) as barring a claim unless "notice" of the claim is given within one year of the accident and the employer had "knowledge" of the injury or condition within 90 days.

Furthermore, even though we consider it unnecessary to proceed to the second and third levels of statutory construction, we note that the legislative history of ORS 656.265[4] does not support a conclusion contrary to our interpretation of subsection (4)(a). In fact, the legislative history sheds no light on the issue. We believe, however, that had the legislature intended that a claim not be barred under ORS 656.265(4)(a) so long as the employer had "knowledge" of the injury within one year and "notice" was given within that same time period, it would have discussed this change and so provided in the statute. Consequently, we construe ORS 656.265(4)(a) to mean that a claim is time-barred unless the employer had notice of the claim within one year and knowledge of the injury within 90 days of the accident.

In this case, as noted above, there is no evidence that the employer had knowledge of claimant's injury within 90 days of its alleged occurrence on March 9, 1997. Therefore, although claimant gave notice of the claim within one year, his claim is nevertheless time-barred under ORS 656.265. *See Tina M. Owens*, 49 Van Natta 1961 (1997) (the claimant's claim untimely where the employer did not have knowledge of the claim, even though she gave written notice of the claim more than 90 days but less than one year after the accident occurred).

Finally, in the alternative, even assuming that claimant's claim was timely, we would agree with and adopt the ALJ's determination that claimant's condition is not compensable. Pursuant to ORS 656.266, claimant has the burden of proving the compensability of his injury. Pursuant to ORS 656.005(7)(a), a compensable injury arises out of and in the course of employment, requires medical services or results in disability and is established by medical evidence supported by objective findings. Here, as the ALJ found, claimant has not presented any medical evidence establishing that he required treatment for a groin condition due to his employment activity on or about March 9, 1997.

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[3] *See McIntire v. Forbes*, 322 Or 426, 431 (1996); *PGE*, 317 Or at 611.

[4] ORS 656.265 was amended in 1995. Prior to that time, *former* ORS 656.265(1) required a worker to give notice of an "accident resulting in injury or death" within 30 days. *Former* subsection (4)(a) provided, in relevant part, that failure to give notice as required barred a claim unless "the employer had knowledge of the injury or death, or the insurer of self-insured employer had not been prejudiced by failure to receive the notice." Even under this version of the statute, a claimant who failed to give timely notice had to show that the employer had knowledge of the injury within the 30 day period. *See, e.g., Danny G. Luehrs*, 45 Van Natta 889, 890 (1993).

ORDER

The ALJ's order dated April 9, 1998 is affirmed.

December 14, 1998 Cite as 50 Van Natta 2343 (1998)

In the Matter of the Compensation of
CLARENCE A. JOB, Claimant
Own Motion No. 98-0467M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable knee strain. Claimant's aggravation rights expired on January 29, 1996. Although recommending that we authorize the payment of temporary disability compensation, the insurer contends that claimant was retired 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. *Id.*

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

The insurer contends that claimant was retired at the time of the current disability and therefore not in the work force. The insurer has not responded to the Board's November 17, 1998 correspondence seeking clarification of the "work force" issue. Furthermore, claimant has not responded to the Board's inquiry nor to the insurer's contention.[1]

Claimant has the burden of proof on this issue and must provide evidence on that issue (*e.g.*, copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question).

The current record does not demonstrate claimant's presence in the work force at the relevant time.[2] Therefore, we are not authorized to award temporary disability compensation. 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.

[1] The November 17, 1998 letter from the Board requested clarification from the insurer regarding its contention that claimant is not entitled to temporary disability because he is retired. The Board requested that such clarification be received within 14 days from the date of the letter. Inasmuch as the 14 day period has expired, we have proceeded with our review.

In the event that claimant disagrees with our decision that he has withdrawn from the work force, he may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, he should submit his information as soon as possible.

[2] On the insurer's own motion recommendation form, claimant's date of birth was listed as 3/12/30, which would mean that claimant's age is 68 years old.

In the Matter of the Compensation of
ELAINE J. KOST, Claimant
Own Motion No. 98-0191M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's October 2, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from March 25, 1998 through May 30, 1998.[1] The employer declared claimant medically stationary as of September 15, 1998.

In an October 27, 1998 letter, we requested the parties to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The employer submitted its response on October 28, 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 a carrier'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 issue 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, claimant notes that, when her claim was closed in 1993, she received a check for what she presumes was her "MMI rating." Based on such circumstances, she wishes to receive similar compensation for her recent surgery. Specifically, she is "appealing this due to the fact that my condition worsened dramatically causing me to need surgery, therefore my mobility is worst then [sic] in 1993 when I received it."

We assume that claimant is not contesting her medically stationary date nor the amount of temporary disability she was awarded.[2] Rather, we interpret her appeal as a request for other workers' compensation benefits (permanent disability).[3] We are 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). As noted in footnote 1, claimant's aggravation rights' expired in 1994, following the 1993 closure of her claim. Thus, whereas she was entitled to a permanent disability rating following the 1993 closure of the claim, she is not statutorily entitled to such a rating under this reopening of her own motion claim.

Accordingly, we affirm the employer's October 2, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Claimant's 1989 claim was first closed on November 1, 1989. Claimant's aggravation rights expired on November 1, 1994. ORS 656.273(4)(a). Thus, when claimant's condition worsened requiring surgery on March 25, 1998, claimant's claim was under our own motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on May 1, 1998, we issued our own motion order authorizing the payment of temporary disability compensation and noted that when claim was medically stationary, the employer should close the claim pursuant to OAR 438-012-0055.

[2] In a September 15, 1998 doctor's report, Dr. Janssen, claimant's attending physician, noted that "[claimant] is clearly at maximal medical improvement." A physical therapy initial evaluation notes that claimant had returned to full time work by May 27, 1998. Further, on July 14, 1998, Dr. Janssen advised that although claimant would not be able to work overtime, she could continue her regular work. These opinions are unrebutted. Thus, even if claimant were contesting her medically stationary date, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed and that she is not entitled to additional temporary disability beyond May 30, 1998. We, therefore, conclude that the employer's closure was proper.

[3] Because of claimant's reference to receiving an "MMI rating" following her 1993 closure, we interpret her inclusion of the term as a request for a permanent partial disability award.

In the Matter of the Compensation of
LOLA R. MORAD, Claimant
WCB Case No. 97-09804
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Bock and Biehl, and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the self-insured employer's denial of her cervical and lumbar conditions, bilateral knee contusions and right leg thrombophlebitis; and (2) declined to assess a penalty for the employer's allegedly unreasonable claims processing. In its respondent's brief, the employer renews its contention that claimant failed to cooperate with the claim investigation process by not attending a scheduled medical examination. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of ultimate finding of fact no. 2. We summarize the pertinent facts as follows:

Claimant, age 41 at the time of hearing, worked as a waitress and "key person" for the employer's restaurant. While at work on July 24, 1997, she slipped and fell in the "slat" room, striking her knees on the concrete floor, with her right knee taking the brunt of the fall. On August 4, 1997, she sought treatment from Dr. Christensen, complaining of persistent cervical and lumbar discomfort and bilateral knee pain. Dr. Christensen diagnosed bilateral knee contusion and mild cervical and lumbar strains. (Ex. 6).

Previously, in 1987, claimant was involved in a motor vehicle accident in which she sustained injuries to her neck, back and knees. X-rays after the accident showed a transitional fifth lumbar segment, narrowed C5-6 disc space and straightening of the cervical spine and loss of usual lordotic curve, and normal osseous structure of both knees. (Exs. 2, 3).

In February 1997, five months prior to the incident at work, claimant saw Dr. Christensen complaining, among other things, of neck pain and myalgia. (Ex. 4). On March 20, 1997, she returned for further evaluation, complaining of worsening musculoskeletal pain in the neck, left shoulder, hips and low back, which she related to her 1987 motor vehicle accident. Dr. Christensen suspected fibromyalgia and prescribed anti-inflammatory medication. He also noted that claimant had mild hepatic dysfunction likely related to chronic Tylenol use. (Ex. 5).

Claimant returned to Dr. Christensen for a follow-up on August 11, 1997. He noted that clinically, claimant's condition was essentially unchanged from her August 4, 1997 examination. (Ex. 9A). Claimant's subjective symptoms progressed, however, particularly in her right leg and knee. On August 21, 1997, Dr. Christensen sent claimant to the vascular lab, where she demonstrated acute thrombophlebitis affecting multiple soleal veins in the right calf. (Exs. 10, 10A).

Dr. Christensen referred claimant to Dr. Hanesworth, who evaluated her on August 27, 1997. Dr. Hanesworth diagnosed degenerative disc disease at C5-6, exacerbated by the July 1997 work injury, low back pain due to a lumbar strain and bilateral leg pain and swelling of uncertain etiology. He found no evidence of any interarticular pathology in claimant's knees except a small hint of calcification of the medical meniscus on the left knee. (Exs. 12, 13). Claimant saw Dr. Hanesworth again on October 13, 1997, where he diagnosed chronic back pain and bilateral leg pain and swelling of uncertain etiology. (Ex. 13)

Meanwhile, on September 8, 1997, claimant saw Dr. Christensen, who noted an exaggerated fibromyalgia component. He noted full range of motion of the knees and slowly resolving cervical and lumbar injuries. (Ex. 14). Similarly, on September 17, 1997 and October 1, 1997, Dr. Christensen noted no objective findings to support claimant's subjective complaints of back and leg pain. He suspected significant functional overlay. (Exs. 15, 16).

On October 7, 1997, claimant was examined by Dr. Neumann at the employer's request. Dr. Neumann noted significant functional overlay and inconsistencies in the examination. He suggested claimant undergo a psychological evaluation. (Ex. 17).

On October 17, 1997, claimant was hospitalized for treatment of deep vein thrombophlebitis (DVT) of the right leg. Dr. Panossian noted DVT risk factors of obesity, trauma, smoking and estrogen use. (Ex. 20). Claimant was discharged on October 21, 1997 and placed on Coumadin. (Ex. 22). Her subjective pain complaints continued.

On October 27, 1997, claimant returned to Dr. Hanesworth. He determined that claimant's back pain was probably due to a degenerative disc segment. Dr. Hanesworth also concurred with Dr. Neumann's report. (Exs. 23, 25).

On November 13, 1997, Dr. Christensen reported that claimant's functional pain behavior and her fibromyalgia component had caused a problem in assessing her overall injuries. He attributed claimant's thrombophlebitis to her relative incapacity, listing her smoking and estrogen use as contributing factors. Dr. Christensen also agreed that a psychological evaluation would be beneficial. (Ex. 29).

Claimant was scheduled for a psychological evaluation on November 24, 1997, which she did not attend due to forecasted inclement weather. On November 25, 1997, Dr. Christensen indicated that claimant did not attend the psychological examination because she was "feeling too ill." He again noted significant functional overlay with some persisting trigger point tenderness. (Ex. 31).

On December 2, 1997, the employer issued a denial asserting that there was insufficient evidence that claimant's current conditions and need for treatment arose out of her unwitnessed slip and fall on July 24, 1997. The employer also noted that claimant failed to attend the medical examination on November 24, 1997, even though the weather conditions in Medford and Klamath Falls were partly cloudy and dry. (Ex. 35).

On January 28, 1998, Dr. Hanesworth opined that claimant's C5-6 degenerative disk disease was unrelated to the July 24, 1997 incident at work, although the incident may have exacerbated her neck symptoms. He also reported that her fibromyalgia, depression and thrombophlebitis conditions were unrelated to the July 24, 1997 incident. (Ex. 40). On February 10, 1997, Dr. Neumann similarly reported that claimant's fibromyalgia and cervical disk disease preexisted her employment and that her thrombophlebitis was unrelated to the July 24, 1997 incident. (Ex. 42).

In February 1998, Dr. Christensen reported that claimant had arthritic and chondrocalcinosis components in her knees as well as fibromyalgia that preexisted the July 24, 1997 incident. (Ex. 41). In a subsequent report, Dr. Christensen opined that claimant sustained bilateral knee contusions and cervical and lumbar strains in the July 24, 1997 incident, and that because she remained immobile following the fall and did not have previous symptoms of thrombophlebitis, the fall at work was the major cause of the thrombophlebitis. (Ex. 43).

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that although claimant presented a credible demeanor, she was not a reliable historian. The ALJ further found that insofar as claimant was not a reliable historian, the medical reports based upon her history (including her descriptions of the July 24, 1997 incident) were unpersuasive. In addition, the ALJ concluded that claimant failed to show by a preponderance of the evidence that her right leg thrombophlebitis was caused in major part by the July 24, 1997 incident.[1]

On review, claimant argues that she sustained bilateral knee contusions, cervical and lumbar strains and thrombophlebitis as a result of her July 24, 1997 fall at work. Specifically, claimant asserts that there is no evidence that her knee and back conditions combined with any preexisting condition to cause or prolong her disability. She further contends that her thrombophlebitis is compensable as a consequential condition of her injury. As set forth below, we find that although claimant sustained bilateral knee contusions and mild cervical and lumbar strains in the July 24, 1997 fall, she has not established the compensability of her cervical and lumbar conditions, lower extremity complaints and thrombophlebitis by a preponderance of the evidence.

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[1] The ALJ did not specifically address the employer's contention that claimant did not cooperate with the claim investigation process. On review, we similarly decline to consider the employer's argument, as there is no evidence in the record that the employer provided proper notice to claimant or that the employer requested that the Director suspend payment of compensation prior to denying benefits based on claimant's alleged noncooperation. *See* ORS 656.262(15) (providing that the carrier may deny the claim based on a worker's failure to cooperate only if the worker does not cooperate for an additional 30 days after the Director's notice concerning cooperation).

We first address claimant's cervical and lumbar conditions. Contrary to claimant's contention, the record establishes that, prior to her July 24, 1997 fall at work, she complained of chronic neck and low back pain which Dr. Christensen attributed to fibromyalgia. The record also establishes that claimant had preexisting degenerative disk disease at C5-6. Although Dr. Christensen diagnosed mild cervical and lumbar strains and bilateral knee contusions related to claimant's fall at work, he indicated that her preexisting fibromyalgia component contributed to her disability and need for treatment. Indeed, by early September 1997, Dr. Christensen reported that claimant's exaggerated pain response was probably due to her underlying fibromyalgia component. Dr. Hanesworth, on the other hand, opined that claimant's preexisting C5/6 degenerative disc disease contributed to her neck pain.

Considering the above medical evidence, we are persuaded that the cervical and lumbar injuries sustained in the July 24, 1997 fall combined with claimant's preexisting fibromyalgia and C5-6 disc disease to cause or prolong her disability and need for treatment. Consequently, the compensability of claimant's cervical and lumbar conditions must be determined under the major contributing cause standard of ORS 656.005(7)(a)(B). In other words, claimant must prove that her July 24, 1997 work injury was the major contributing cause of her disability or need for medical treatment for these combined conditions. *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309, 312 (1997).

Determining the "major contributing cause" of a disease or injury involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"). Furthermore, "major contributing cause" means that the work activity or exposure contributes more to causation than all other causative agents combined. *McGarrah v. SAIF*, 296 Or 145, 166 (1983).

After considering the expert medical evidence, particularly the reports of Drs. Christensen and Hanesworth, we are not persuaded that the July 24, 1997 incident was the major cause of claimant's cervical and lumbar disability or need for treatment. Indeed, neither doctor specifically identified the fall as the primary cause of her neck and back pain. Dr. Hanesworth opined that although the work incident may have exacerbated claimant's neck symptoms, it was not the primary cause of her cervical condition. Dr. Christensen noted on several occasions that claimant's functional overlay and fibromyalgia component contributed to her disability and complicated her recovery. Consequently, we find that claimant has not proven the compensability of her cervical and lumbar conditions by a preponderance of the medical evidence. ORS 656.266.

With regard to claimant's knee complaints, the record establishes that, in addition to fibromyalgia, claimant also had preexisting arthritic and chondrocalcinosis (although these latter conditions were apparently asymptomatic until claimant's July 24, 1997 fall). On August 4, 1997, eleven days after the incident, Dr. Christensen noted bilateral knee tenderness and patellar swelling, and diagnosed bilateral contusions. The August 5, 1997 knee x-rays showed no acute fracture injury, but Dr. Christensen reported that clinically, claimant had bruising on both patella tendons. By August 27, 1997, however, Dr. Hanesworth found no evidence of an acute knee injury, and did not relate claimant's bilateral leg and knee pain to the July 24, 1997 fall. Indeed, he considered her leg pain of "uncertain etiology." Similarly, in early September 1997, Dr. Christensen reported that claimant's functional overlay and fibromyalgia components were contributing to her ongoing leg and knee complaints. He could find no objective basis for her pain.

Given the above evidence, we are persuaded that claimant sustained bilateral knee contusions as a result of her July 24, 1997 fall.[2] We find, however, that these contusions resolved by August 27, 1997 (when Dr. Hanesworth found no evidence of an acute knee injury). But to the extent claimant experienced ongoing leg pain and swelling (documented by Dr. Hanesworth after her contusions had

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[2] Unlike the dissent, we consider claimant's bilateral knee contusions (which, according to Dr. Christensen, were evidenced by bruising, tenderness and patellar swelling) as a separate injury, and not part of a combined condition. None of the medical experts opined that claimant's knee contusions involve a combination of factors. Furthermore, unlike claimant's other claimed conditions (which do involve combined conditions), claimant's bilateral knee contusions present a simple case. Therefore, direct medical evidence establishing causation is not required. *See, e.g., Barnett v. SAIF*, 122 Or App 279 (1993) (expert medical evidence not required to prove causation in uncomplicated cases).

resolved), we are not persuaded that these symptoms were caused in material or major part by the work incident. Rather, we accept Dr. Hanesworth's opinion that claimant's ongoing lower extremity complaints were of uncertain etiology.

With regard to the thrombophlebitis, insofar as claimant contends this condition developed as a consequence of her knee injury, she must prove that the compensable injury was the major contributing cause of this condition. ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Although Dr. Christensen opined that claimant's fall at work was the major cause, we are unpersuaded by this opinion.[3] First, Dr. Christensen's opinion was premised on the fact that claimant "remained immobile following her recovery from the fall." (Exs. 29, 43). However, as discussed above, to the extent claimant was incapacitated after her fall, she has not shown that this incapacity was caused in major part by the fall itself.[4] To the contrary, the evidence establishes that claimant's disability subsequent to the work incident was due in significant part to noncompensable conditions, including her underlying fibromyalgia component. Therefore, Dr. Christensen's opinion does not establish that the July 24, 1997 incident was the major cause of claimant's right leg thrombophlebitis. Furthermore, Dr. Christensen acknowledged that claimant's smoking, obesity, use of Premarin, as well as her stopping use of prophylactic aspirin contributed to the development and worsening of her thrombophlebitis, without explaining why all these factors, taken together, were less of a cause than her relative incapacity in August 1997. Accordingly, like the ALJ, we find that claimant has not established the compensability of her thrombophlebitis as a consequential condition.

Claimant also argues that the employer's denial was unreasonable. We disagree. The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

Although we find claimant's bilateral knee contusions compensable, we conclude that, considering claimant's preexisting, underlying conditions, multiple complaints and subsequent functional overlay, the employer had a legitmate doubt as to the compensability of the claim in general. Therefore, no penalty is warranted.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for partially prevailing over the employer's denial with regard to the bilateral knee contusions. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the bilateral knee contusion compensability issue, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved (nondisabling contusions which resolved within a month), and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated May 28, 1998 is reversed in part and affirmed in part. That part of the order that upheld the employer's denial insofar as it denied claimant's bilateral knee contusions is set aside, and claimant's claim for that condition is remanded to the employer for processing according to law. The remainder of the denial is upheld. For services at hearing and on review with regard to the bilateral knee contusion claim, claimant's counsel is awarded $1,000, payable by the employer. The remainder of the ALJ's order is affirmed.

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[3] Unlike Dr. Christensen, both Dr. Hanesworth and Dr. Neumann opined that claimant's thrombophlebitis was not related to the July 24, 1997 incident. (Exs. 40, 42).

[4] Although we find that claimant sustained bilateral knee contusions (bruising) as a result of the July 24, 1997 fall, the record does not establish that this condition caused claimant's incapacity.

Board Member Moller concurring in part and dissenting in part.

Although I agree with the majority that claimant has not established the compensability of her cervical and lumbar conditions, lower extremity complaints and thrombophlebitis, I would also find that claimant has not proven the compensability of any bilateral knee condition. Consequently, I respectfully dissent in part.

After considering the record as a whole (particularly the varying histories and descriptions of the July 24, 1997 work incident that claimant provided to various health care providers and at hearing), I would find, as did the ALJ, that claimant was not a reliable historian. Given claimant's unreliability, I would find the medical reports based upon her history unpersuasive and insufficient to sustain her burden of proof, including with regard to her claim for bilateral knee contusions. In particular, I would note claimant's varying histories as to whether she struck both knees -- or solely her right knee -- in the incident.

Furthermore, unlike the the majority, I am unable to conclude that the issue of compensability of the claim for bilateral knee contusions is a simple case for which no direct medical evidence establishing causation is required. (*See* Majority opinion, n 2). Claimant previously injured both of her knees in a motor vehicle accident in 1987, which reportedly resulted in a left knee medial meniscectomy. (Ex. 17-3). Following an August 21, 1997 examination, Dr. Christensen diagnosed, among other things, "bilateral knee contusion with chondrocalcinosis." Moreover, Dr. Christensen subsequently agreed that claimant had arthritic and chondrocalcinosis components of the knees, as well as fibromyalgia, that preexisted the July 24, 1997 incident. Given these complicating factors, I cannot conclude that the compensability issue is so simple as to not require expert medical evidence.

Moreover, Dr. Christensen's diagnosis of "bilateral knee contusions with chondrocalcinosis" indicates that claimant's knee contusions combined with her preexisting knee condition to cause or prolong her disability and need for treatment. There is no evidence indicating that the fall was the major cause of this combined bilateral knee condition. *See* ORS 656.005(7)(a)(B). To the contrary, Dr. Christensen suspected that claimant was displaying "significant functional overlay" and that her functional pain behavior and her fibromyalgia component caused difficulties in assessing her overall injuries. He reinforced to claimant and her husband "that her physical coomplaints [were] out of line with objective findings and injury history." (Ex. 16). In light of this record, I would conclude that claimant has presented no persuasive evidence that the alleged knee contusions required medical treatment or resulted in disability. *See* ORS 656.005(7)(a).

For these reasons, I would affirm the ALJ's order upholding the employer's denial in all respects.

December 11, 1998 Cite as 50 Van Natta 2349 (1998)

In the Matter of the Compensation of
RANDOLPH KING, Claimant
WCB Case No. 98-03799
ORDER OF ABATEMENT
Steven M. Schoenfeld, Claimant Attorney
Reinisch, et al, Defense Attorneys

Claimant requests abatement and reconsideration of our November 12, 1998 Order of Dismissal concluding that, because the record did not establish that the Board received a timely request for review of the Administrative Law Judge's order, we lacked jurisdiction to consider the matter. The self-insured employer has responded to claimant's motion and urges us to affirm our order.

In order to consider this matter, we withdraw our November 12, 1998 order. Claimant may file a reply brief 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
DARLENE TRELSTAD-PETERSON, Claimant
WCB Case No. 97-10376
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that upheld the self-insured employer's denial of claimant's occupational disease claim for right shoulder, arm, and wrist tendonitis. On review, the issue is compensability.

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

We do not find that Dr. Gallegos' opinion is "internally conflicting," because she explained her otherwise inconsistent concurrence with Dr. Button's report. (*See* Ex. 14-13). Nonetheless, we do find Dr. Gallegos' opinion unpersuasive because it is based on an inadequate history regarding claimant's work activities.

Dr. Gallegos noted that claimant's right upper extremity problems began soon after her job began requiring a "lot more writing," specifically handwriting with pressure sufficient to make two carbon copies. (*See* Exs. 2, 12, 14-8). But Dr. Gallegos admitted that she did not know how repetitive claimant's work-related writing was, and that would be important to her causation opinion. (*See* Exs. 14-8-9, 14-16; *but see* Ex. 14-10[1]). Under these circumstances, we cannot say that Dr. Gallegos' causation opinion is based on a complete history.[2] In addition, Dr. Burton noted that claimant's upper extremity symptoms were bilateral, whereas her writing was a "unilateral task." (Ex. 9-4). Dr. Gallegos did not address this "unilateral task vs. bilateral symptoms" point. In light of such circumstances, we agree with the ALJ that Dr. Gallegos' opinion is not persuasive and claimant has not carried her burden of proof.

ORDER

The ALJ's order dated August 7, 1998 is affirmed.

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[1] Dr. Gallegos first stated that the amount of writing would bear on her causation opinion, if it was "one versus a hundred a day," then she stated, "It didn't matter to me because that was the only kind of new activity. . . .I figured she was doing more than one a day and probably several, whatever that meant." (*Id*). We agree with the ALJ that Dr. Gallegos' opinion is based largely on the temporal relationship between claimant's new job duties and her symptoms. Moreover, to the extent that the doctor's opinion is based on the repetitive or quantitative nature of claimant's work, we find her history in this regard inadequate.

[2] The record indicates that claimant's handwriting at work was limited to filling out a maximum of 18 half-page forms (*i.e.*, equivalent to nine full pages) per day.

In the Matter of the Compensation of
DANIEL L. PASSON, Claimant
WCB Case No. 97-07535
ORDER OF DISMISSAL
James B. Northrop (Saif), Defense Attorney

On December 2, 1998, the Board received claimant's request for review of Administrative Law Judge (ALJ) Nichol's May 18, 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 May 18, 1998, the ALJ issued an Opinion and Order upholding the SAIF Corporation's denial of claimant's current condition claim. Copies of that order were mailed to claimant (who is *pro se*), the employer, SAIF, and SAIF's 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 December 2, 1998, the Board received a November 30, 1998 letter from SAIF enclosing claimant's request for review and asking the Board if it planned to "issue" a "Notice of Briefing." Attached to the correspondence was a letter dated May 29, 1998 from claimant to the Board requesting review of the ALJ's order.

On December 4, 1998, the Board mailed its computer-generated letter to all parties acknowledging its receipt 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. 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 18, 1998 order was June 17, 1998. Claimant's My 29, 1998 letter indicates that he was requesting Board review of the ALJ's order. Although the May 29, 1998 letter is *dated* within 30 days of the ALJ's September 8, 1998 order, the record fails to show that the Board *received* the request prior to expiration of the statutory 30-day period.[1] Instead, the Board's first receipt of that letter occurred on December 2, 1998, when it received the May 29, 1998 letter along with SAIF's November 30, 1998 letter. Consequently, the record does not establish that claimant filed a request for review prior to the expiration of the statutory appeal period.[2]

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[1] Claimant may submit information for our consideration showing that he mailed a request for review to the Board within 30 days of the ALJ's order. 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.

[2] Based on SAIF's November 30, 1998 letter, we are persuaded that it received timely notice of claimant's request for Board review.

Considering the November 30, 1998, correspondence as a request for review, claimant's filing is untimely. Therefore, 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
RONALD L. CLARK, Claimant
Own Motion No. 93-0660M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 9, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from January 12, 1994 through October 1, 1998. SAIF declared claimant medically stationary as of October 1, 1998.

In an October 22, 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. Having received the parties' respective submissions, 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, it is not apparent on which ground claimant is contesting SAIF's notice of closure. Rather, in his October 16, 1998 letter, claimant simply states that he is requesting Board review of SAIF's closure. We assume that claimant is contesting both his medically stationary status and temporary disability award.

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 October 9, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On May 21, 1998, Dr. Patterson, claimant's attending physician, reported that claimant required two additional surgeries, one to remove a fixation screw and the other, a heel osteotomy. However, before attempting either surgery, Dr. Patterson recommended that claimant undergo a "significant weight reduction."

On August 25, 1998, Dr. Patterson noted that claimant continued to experience lateral heel and foot pain. Although still recommending surgery, Dr. Patterson observed that "[claimant] has not lost any weight and it would be inadvisable to operate till further weight loss is obtained." Scheduling claimant for a "six month follow up," Dr. Patterson concluded "[T]he claim may close till the [claimant] has lost the appropriate amount of weight."

In an October 1, 1998 response to SAIF's inquiry, Dr. Patterson opined that claimant's condition "would be considered to be stable till he is able to obtain a 50 LB weight loss. I have told the [claimant] that this is the case and that, when he is able to muster this degree of loss, we will then be able to reopen the claim."

In cases where claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if claimant refuses the surgery. *e.g. Stephen L. Gilcher*, 43 Van Natta 319, 320 (1991); *Karen T. Mariels*, 44 Van Natta 2452, 2453 (1992). However, if postponement (as opposed to refusal) of surgery is beyond the claimant's control and is medically necessary for the compensable condition, we have held that the claim was closed prematurely since, at closure, there was still a reasonable expectation for improvement based on the surgery recommendation. *See Bill H. Davis*, 47 Van Natta 219 (1995).[1]

Here, surgery has been recommended that could result in the material improvement of claimant's condition. However, Dr. Patterson recommended that claimant lose weight before scheduling the surgery. Dr. Patterson has not altered his opinion that, in absence of such weight loss, claimant was medically stationary.[2] Under such circumstances, we conclude that claimant was medically stationary at the time his claim was closed.[3] *Stephen L. Gilcher, supra.*

Accordingly, we affirm SAIF's October 9, 1998 Notice of Closure in its entirety.[4]

IT IS SO ORDERED.

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[1] Here, unlike in *Davis*, claimant's doctor declared him medically stationary until the requisite amount of weight loss is achieved. The record lacks medical evidence that claimant has satisfactorily complied with his doctor's recommendation.

[2] Claimant submitted an November 17, 1998 affidavit wherein he attests that he has lost weight and even demonstrated said weight loss to Dr. Patterson during an August 25, 1998 examination. 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 his burden of proof by providing a *medical opinion* that would support his contention that he was not medically stationary when his claim was closed on October 9, 1998.

[3] Based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed and, therefore, not entitled to additional temporary disability beyond October 1, 1998.

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

In the Matter of the Compensation of
JAMES V. COMPTON, Claimant
WCB Case No. C8-02692
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Schneider, et al, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On November 24, 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 December 8, 1998, we received the SAIF Corporation's addendum to the CDA. We treat SAIF's addendum as a motion for reconsideration of the approved CDA. In order to be considered, a motion for reconsideration of the CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Here, the CDA was approved and mailed on November 24, 1998. We received SAIF's addendum to the CDA on December 8, 1998, 14 days after the CDA was approved. Inasmuch as the motion for reconsideration was untimely, we cannot consider it. OAR 438-009-0035(1),(2); *Edward C. Steele*, 48 Van Natta 2292 (1996); *Paul J. LaFrance*, 48 Van Natta 306 (1996).

Moreover, we approved the CDA in a final order pursuant to ORS 656.236. The approved CDA is final and is not subject to review. ORS 656.236(2). Consequently, we lack either statutory or regulatory authority to alter the previously approved CDA.

IT IS SO ORDERED.

December 16, 1998 Cite as 50 Van Natta 2354 (1998)

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 96-0253M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

On March 17, 1998, the insurer requested suspension of claimant's own motion benefits because he "abandoned his medical care." We requested the parties' positions regarding the insurer's request for suspension. While awaiting claimant's response to the insurer's contentions, the insurer issued a Notice of Closure on June 15, 1998, which closed his claim with an award of temporary disability compensation from May 29, 1997 through June 2, 1998. The insurer declared claimant medically stationary as of June 2, 1998. Claimant requested review of the insurer's closure, contending that he is entitled to additional benefits as he was not medically stationary when his claim was closed. Inasmuch as the insurer closed claimant's claim, its request for suspension of benefits is moot. Claimant's request for review of the insurer's Notice of Closure is at issue. Having received the parties' submissions and respective positions, we proceed with our review.

FINDINGS OF FACT

On June 18, 1996, we issued our Own Motion Order which authorized the payment of temporary disability compensation beginning May 29, 1996, the date claimant underwent surgery which included an iliac crest graft, Achilles tendon lengthening, and subtalar and ankle effusion. Following his surgery, claimant suffered complications and on November 12, 1996, underwent irrigation and debridement of the iliac crest wound.

During the year following his May 29, 1996 surgery, claimant required in-home nursing care to help his iliac crest wound heal. In June 1997, Dr. Coughlin formally requested authorization to proceed with foot surgery; *i.e.* a transverse arthrodesis and first metatarsal osteotomy. The insurer authorized the surgical procedure, which was scheduled for August 20, 1997. However, on August 8, 1997, Dr. Coughlin canceled the surgery because of an "increase chance of infection" (claimant was diagnosed with scabies).

Surgery was rescheduled for October 15, 1997. However, claimant missed the surgery. Although releasing claimant from his care, Dr. Coughlin reported that further care was needed and referred him to Dr. Waters.

Dr. Waters began treating claimant on January 2, 1998. Although concluding that claimant needed the recommended surgery, Dr. Waters noted that claimant had declined surgery to pursue conservative management. Dr. Waters further explained that if claimant was compliant with his recommendations regarding a psychiatric consult, multi-discipline pain management, weight reduction and physical therapy, he would be a good surgical candidate.

On May 19, 1998, Dr. Waters referred claimant to the Elks Rehabilitation Center. Due to transportation problems, claimant was unable to attend the program. When claimant was able to move closer to the center (resolving his transportation problems), he was advised that his appointments "will no longer be paid for."

Claimant attended an insurer-paid medical examination (IME) on June 2, 1998. The IME examiner concluded that: (1) claimant was medically stationary regarding his left ankle; (2) no further treatment was necessary on an industrial basis; and (3) surgery was not reasonably indicated. Dr. Waters concurred with the IME on June 9, 1998. The insurer issued its Notice of Closure on June 15, 1998, declaring claimant medically stationary as of June 2, 1998.

On September 8, 1998, the insurer submitted another own motion recommendation form, which asserted that it was not contesting the compensability of and/or responsibility for claimant's current left foot condition. It further contended that claimant's required surgery, a mid foot osteotomy, was reasonable and necessary. Although the insurer recommended reopening, it contended that claimant was not in the work force at the time of the current worsening.

The insurer submitted its recommendation, relying on an August 25, 1998 medical report from Dr. Waters. In that report, Dr. Waters opined that claimant's current condition was the same as when the 1997 surgery was recommended.

CONCLUSIONS OF LAW

"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 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 support of its closure, the insurer relies on the June 2, 1998 IME report and Dr. Waters' "check-the box" concurrence. However, subsequent to the June 15, 1998 claim closure, Dr. Waters authored the August 25, 1998 report which offers a different opinion regarding claimant's medically stationary status at the time of claim closure. Dr. Waters provided the following explanation:

> "I am not aware of any specific event which occurred on June 9th and July 21st which could have severely worsened [claimant's] symptoms. I do, however, believe that the surgery which has been suggested by Dr. Coughlin and by me is a direct relationship to his original work injury on 3/31/86. *** I have reviewed the case with Dr. Michael Coughlin and he is in agreement in proceeding with the surgery."

Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Here, Dr. Waters has opined that claimant still requires a surgery that was first recommended in 1997. The surgery recommended by Dr. Coughlin and subsequently endorsed by Dr. Waters is designed to materially improve claimant's compensable injury. Further, Dr. Waters opined that nothing has worsened claimant's condition since June 15, 1998. Inasmuch as the record does not suggest that claimant's condition changed between the June 1998 claim closure and Dr. Waters' August 1998 report, we conclude that Dr. Waters' August 1998 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622.[1]

Dr. Waters' opinion that claimant is in need of a mid foot osteotomy has not changed since he first concurred with Dr. Coughlin's recommendation in January 1998. Both physicians agree that claimant's compensable condition would materially improve with the recommended surgery. Claimant has not suffered a new injury to his compensable condition.[2]

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[1] In light of Dr. Waters' original opinion expressed in his one word "check-the-box" concurrence with the IME's June 1998 "medically stationary" report, the August 1998 report is sufficiently explained to overcome the initial "check-the-box" opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive).

[2] We note that the IME report addressed the medically stationary status of claimant's left *ankle*, whereas the proposed surgery involves claimant's left *foot*. Inasmuch as the insurer has not denied claimant's current left *foot* condition and, in fact, has recommended reopening of the claim based on the proposed surgery, we consider claimant's compensable condition to encompass both his left foot and ankle.

Under such circumstances, we conclude that claimant was not medically stationary on June 2, 1998 when his claim was closed by the insurer. Accordingly, we set aside the Notice of Closure as premature and remand the claim to the insurer for further processing in accordance with law. When appropriate, the claim shall be closed by insurer pursuant to OAR 438-012-0055.[3]

IT IS SO ORDERED.

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[3] In light of our finding that the claim was prematurely closed, we have dismissed the insurer's September 8, 1998 own motion recommendation in a separate order.

In the Matter of the Compensation of
RICHARD A. SCHIEL, Claimant
Own Motion No. 97-0374M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Glen J. Lasken, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

On September 21, 1998, we withdrew 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 he was in the work force at the time of his current disability. We took this action to consider claimant's request for reconsideration. After considering claimant's request and the self-insured employer's response, we issue the following order.

With his request for reconsideration, claimant submits a September 14, 1998 affidavit attesting that he was willing to work and had been seeking work at the time his condition worsened requiring surgery. In response, the employer argues that claimant's September 14, 1998 affidavit is not persuasive evidence that he was in the work force at the time of his current disability.

After reviewing the current record and considering the parties' respective positions, we find it appropriate to refer this dispute to an Administrative Law Judge (ALJ) for the further development of the record. *See* OAR 438-012-0040. In this way, the assigned ALJ will have an opportunity to fully evaluate the reliability of the documentary evidence, in light of the credibility of testimonial evidence presented by the parties at the hearing regarding this disputed "work force" issue.

Accordingly, we refer this matter to the Hearings Division for an evidentiary hearing. The parties shall present to the assigned ALJ at the hearing any testimonial and additional documentary evidence concerning the work force issue. Thereafter, the ALJ shall make findings of fact regarding whether claimant was in the work force at the time of disability, and forward a written recommendation to the Board. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). Following receipt of the ALJ's recommendation, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DENISE L. ALLEN, Claimant
WCB Case No. 98-02759
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Bostwick, 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) Marshall's order that declined to assess sanctions against claimant's attorney for an allegedly frivolous request for hearing pursuant to ORS 656.390. Claimant has filed a request for sanctions against the employer's attorney for an allegedly frivolous request for Board review. On review, the issue is sanctions.

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

Claimant has an accepted claim for a nondisabling lumbar strain with the employer. A prior ALJ set aside the employer's denial of claimant's L4-5 herniated disc condition, which the employer had denied on the basis that it was unrelated to the accepted lumbar strain. The prior ALJ also assessed a 25 percent penalty pursuant to ORS 656.262(11) on all compensation "then due" as of January 4, 1996 (the date that the employer untimely complied with claimant's discovery request). In assessing the penalty, the prior ALJ acknowledged that if there were no amounts then due, the amount of the penalty would be zero. On January 4, 1996, the claim was in denied status.

Claimant requested a hearing, seeking enforcement of the prior ALJ's penalty assessment. Meanwhile, the Board adopted and affirmed the prior ALJ's order. The Board's decision was not appealed and has become final.

Claimant argued before the present ALJ that she was entitled to the penalty awarded by the prior ALJ and that the penalty should be based on unpaid medical bills received by the employer on or before January 4, 1996. The employer argued that claimant had not established that the medical bills were unpaid as of January 4, 1996, or, alternatively, that the medical bills could not serve as the basis for a penalty under ORS 656.262(11).

The ALJ agreed with the employer's first argument and found that claimant had failed to establish that there was unpaid compensation as of January 4, 1996 upon which to base a penalty. On this basis, the ALJ found that no penalty or related attorney fee could be awarded for the employer's failure to pay the penalty awarded by the prior ALJ.

The ALJ also declined to impose sanctions against claimant's attorney. The ALJ found that the fact that the prior ALJ had awarded a penalty which was affirmed by the Board gave claimant a colorable argument that she was entitled to a penalty. In addition, the ALJ noted that there was conflicting case law concerning whether a penalty could be based on unpaid medical bills. Accordingly, the ALJ concluded that the request for hearing was not frivolous and declined to impose sanctions.

On review, the employer argues that the cases cited by the ALJ and claimant for the proposition that a penalty can be based on unpaid medical bills are distinguishable. In addition, the employer argues that claimant put forth no other evidence of unpaid compensation. For these reasons, the employer argues that claimant's hearing request was frivolous and that sanctions should be imposed.[1]

Claimant argues that there is case law which suggests that unpaid medical bills can constitute amounts then due upon which to base a penalty under ORS 656.262(11). In addition, claimant argues that, given the case law supporting a penalty based on unpaid medical bills, the employer's request for review seeking sanctions is frivolous. Claimant seeks sanctions against the employer's counsel pursuant to ORS 656.390.

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[1] The employer also seeks sanctions for claimant's allegedly frivolous request for reconsideration of the ALJ's order. ORS 656.390 provides for sanctions for a frivolous request for hearing, but does not specifically provide for sanctions for motions for reconsideration of ALJ or Board orders. In any case, for the reasons expressed in this order, we do not find the request for hearing or the subsequent motion for reconsideration to be frivolous.

ORS 656.390(1) allows the Board to impose an appropriate sanction against an attorney who files a frivolous request for or review. "'[F]rivolous' means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2); *see Westfall v. Rust International*, 314 Or 553, 559 (1992) (defining "frivolous" under former ORS 656.390).

Based on our holding in *Leonard W. Kirklin*, 48 Van Natta 1571 (1996), as well as other cases cited by the ALJ and the parties, there is support for claimant's contention that medical services are generally considered "amounts then due" upon which a penalty under ORS 656.262(11) can be assessed. The employer argues that *Kirklin* and the other cases cited by claimant are distinguishable because the present case involves enforcement of a penalty for a discovery violation that occurred when the claim was denied and the cases cited by claimant involve unreasonable denials or penalties for late paid medical bills.

Although unpaid medical bills may in some circumstances be considered "amounts then due" on which a penalty under ORS 656.262(11) can be based, in this case, the prior ALJ assessed the penalty on amounts then due as of the date the discovery was finally provided, January 4, 1996. On that date, the claim was in denied status. The employer was not required to pay medical benefits before or after it denied the claim. *See* ORS 656.262(2),(6); *Conagra Inc. v. Jeffries*, 118 Or App 373, 376 (1993) (benefits, including medical benefits, become due as of the date the denial is set aside). The denial was not set aside until the date of the prior ALJ's order, June 18, 1996. Thus, the medical bills were not amounts then due until the date of the prior ALJ's order setting aside the denial. Under the circumstances of this case, the medical bills were not amounts then due as of January 4, 1996, the date the late discovery was provided.

Nevertheless, we do not find claimant's hearing request to be frivolous. In this regard, we agree with and have adopted the ALJ's conclusion that the fact that the earlier ALJ awarded a penalty and the Board affirmed the penalty award, gave claimant a colorable argument that she was entitled to enforcement of the penalty. Accordingly, we do not find claimant's hearing request to be frivolous and we deny the motion for sanctions.

Claimant seeks sanctions against the employer's attorney under ORS 656.390 for an allegedly frivolous request for Board review. As explained above, because the claim was in denied status, the medical benefits were not amounts then due at the time the prior ALJ assessed the penalty for the discovery violation. Under such circumstances, the employer had a colorable argument that claimant's attorney's actions in requesting a hearing seeking enforcement of the penalty were "frivolous." Thus, we find that sanctions are not appropriate.

ORDER

The ALJ's order dated July 29, 1998, as reconsidered on August 10, 1998, is affirmed.

In the Matter of the Compensation of
ELIZABETH A. BORST, Claimant
WCB Case No. 98-01532
ORDER ON REVIEW (REMANDING)
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed claimant's request for hearing with prejudice. On review, the issues are: (1) propriety of the ALJ's dismissal order; and (2) remand. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant has an accepted claim for a 1980 injury with the employer. In February 1998, the insurer issued a denial of claimant's current condition. Claimant retained counsel and filed a request for hearing from the current condition denial. The matter was set for hearing on May 12, 1998, and notice of that hearing was mailed to claimant's last known address.

By letter dated May 7, 1998, claimant's counsel informed the Board that he was withdrawing his representation of claimant. That announcement was received by the Hearings Division on May 8, 1998. Neither claimant nor her former counsel requested a postponement of the scheduled hearing. On May 12, 1998, the matter proceeded to hearing, and claimant did not appear in person or through counsel. The insurer moved for dismissal of claimant's hearing request on the ground that she had abandoned her claim. On May 12, 1998, the ALJ issued an Order of Dismissal.

Claimant, *pro se*, filed a request for reconsideration of the ALJ's dismissal order. Stating that she did not appear at the scheduled hearing on the advice of her prior counsel and representing that she was seeking a new attorney to obtain new evidence to support her claim, claimant disagreed with the ALJ's dismissal order. In response, the insurer asserted that claimant's "change of heart" regarding her former attorney's advice not to attend the hearing did not constitute "extraordinary circumstances" to warrant the postponement of the hearing.

After considering the parties' arguments regarding the propriety of the dismissal, the ALJ issued a June 15, 1998 Order on Reconsideration that republished the initial dismissal order. This matter is now before the Board pursuant to claimant's request for Board review of the ALJ's dismissal order.

CONCLUSIONS OF LAW AND OPINION

When a party requests a hearing but fails to appear in person or by counsel, the ALJ shall dismiss the request for hearing as having been abandoned unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). A scheduled hearing shall not be postponed except by order of an ALJ upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. OAR 438-006-0081. "Extraordinary circumstances" does not include incomplete case preparation, unless the ALJ finds that completion of the record could not be accomplished with due diligence. OAR 438-006-0081(4).

Here, the ALJ concluded that the circumstances surrounding claimant's failure to appear at hearing were not "extraordinary." The ALJ reasoned that claimant's sole stated reason for failing to appear at the hearing was the advice of her former attorney, and claimant's choice to heed that advice was voluntary and not beyond her control.

As the ALJ has considered and rejected claimant's argument that extraordinary circumstances exist, it is appropriate for the Board to address this issue on review. *Accord Jerry R. Testerman*, 46 Van Natta 1114 (1994).[1] After considering this record, we are persuaded that extraordinary circumstances beyond claimant's control justify the postponement of her scheduled hearing. In reaching this conclusion, we note that claimant's former attorney withdrew his representation five days before the scheduled hearing; claimant did not appear at the May 12, 1998 hearing based on the advice of her former counsel; and she was seeking a new attorney with the intention of pursuing the litigation of her claim when her hearing request was dismissed.

Under these circumstances, we conclude that claimant's failure to appear at hearing was not due to "incomplete case preparation" that could have been accomplished with "due diligence." *See* OAR 438-006-0081(4). We further conclude that these are "extraordinary circumstances" beyond claimant's control justifying a postponement of claimant's hearing request. *See* OAR 438-006-0081; *Alan J. Davis*, 47 Van Natta 274 (1995) (extraordinary circumstances justified the postponement of the claimant's hearing when his attorney was terminated 7 days before the hearing). Consequently, claimant's hearing request should be reinstated and a hearing rescheduled.

Moreover, the same circumstances persuade us that remand is appropriate under ORS 656.295(5) because this record has been insufficiently developed.[2] Accordingly, the ALJ's order is vacated and this

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[1] *Compare Jennie S. Debelloy*, 49 Van Natta 134 (1997) (case remanded to ALJ to consider claimant's challenge to dismissal order where ALJ did not previously have the opportunity to consider claimant's opposition to the dismissal).

[2] Pursuant to ORS 656.295(5) "[i]f the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Administrative Law Judge, it may remand the case to the Administrative Law Judge for further evidence taking, correction or other necessary action." 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).

matter is remanded to the ALJ to schedule a hearing on the merits. At that hearing, the parties shall have the opportunity to present evidence regarding the issues raised by claimant's hearing request.

ORDER

The ALJ's order dated May 12, 1998, as reconsidered June 15, 1998, is vacated. The case is remanded to Administrative Law Judge Brazeau for proceedings consistent with this order.

December 17, 1998 Cite as 50 Van Natta 2360 (1998)

In the Matter of the Compensation of
DEBRA L. COKER, Claimant
WCB Case No. 98-02028
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the SAIF Corporation's denial of claimant's claim for an injury sustained during a physical abilities test. On review, the issue is whether the injury occurred within the course and scope of claimant's employment.

We adopt and affirm the ALJ's order as modified below.

The ALJ concluded that claimant's injury claim was not compensable because the insured was not claimant's "employer" at the time of the injury. An employer is defined as "any person * * * who contracts to pay remuneration for and secures the right to direct and control the services of any person." ORS 656.005(13)(a).

Here, claimant injured herself during a physical abilities test that was a prerequisite to obtaining a permanent appointment with the employer as a Group Life Coordinator (GLC) 2. At the time of the injury, claimant was completing the last month of a temporary, six-month appointment to the same position, and the employer had authorized an extension of this appointment for another six-month period.[1] Claimant had also applied for a permanent appointment to this position. All applicants for a permanent appointment as a GLC 2 were required to pass a physical abilities test. The employer did not require employees to pass the test in order to retain or extend a temporary appointment. On December 30, 1997, claimant was injured while participating in the physical abilities test required for a permanent appointment.

In concluding that the insured was not claimant's employer at the time of the injury, the ALJ found that the test was not a requirement of claimant's continued employment as a *temporary* GLC 2. On review, claimant argues that the insured was, nonetheless, her "employer" at the time of injury because she reasonably believed she had to pass the physical abilities test to continue her temporary employment. In responding to this same argument, the ALJ concluded that claimant's perception was not determinative because the record otherwise established that the employer did not, in fact, require passage of the physical abilities test as a requirement for continued temporary employment. We offer the following alternative rationale.

Claimant relies on the following cases in support of her argument: *Ramseth vs. Maycock*, 209 Or 66 (1956) (in "course and scope" analysis, employment relationship encompasses activities presented to the employee under such circumstances that he would consider it detrimental to his employment status to refuse); *Town & Country Chrysler v. Mitchell*, 113 Or App 434 (1992) (in "course and scope" context, employer brings social or recreational activity within the orbit of employment by implied requirement of participation); and *Newport Seafood v. Shine*, 71 Or App 119, 124 (1984) (in context of "loaned servant" doctrine, determination of an employment relationship focuses first on the claimant's perspective).

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[1] Claimant had previously served a six-month appointment in the same position from January through June 1997. At the time of the injury, claimant was completing an extension of that appointment from July through December 1997, and the employer had authorized a further extension from January through June 1998.

We assume, for the sake of argument, that the rationale expressed in these decisions is applicable in the present case, and that claimant's injury would be compensable if the record established that passage of the physical abilities test was an implied requirement of claimant's temporary employment. Nevertheless, claimant would not prevail under this assumption for the following reasons.

Claimant's employment relationship with the insured does not extend past her upcoming six-month appointment for the period January through June 1998. Accordingly, to establish that the physical abilities test was an implied requirement of claimant's employment, she must prove that she could not serve out that temporary appointment if she did not pass the test. Claimant testified that she believed she needed to pass the physical abilities test to continue to be a temporary employee of the insured. However, it is not clear whether claimant was referring to the authorized six-month appointment from January through June 1998, or to future temporary appointments. And claimant did not rebut the testimony of her co-worker, Keasha Pounds, that she and claimant thought that the physical abilities test was required for obtaining future six-month appointments, as distinct from completing previously authorized temporary appointments.

Moreover, the insured's December 15, 1997 letter to claimant clearly suggests that the physical abilities test was a prerequisite for future appointments. That letter reads in pertinent part:

> "Thank you for your response to our notice of the new *entry* standards for the classification of Group Life Coordinator 2[.] We have received your certification verifying you meet the minimum age, education level and possess a valid driver's license. * * * Another part of the new *pre-employment* qualification process is the ability to pass a physical abilities test. * * * Because this is a pre-employment process, *there will be no compensation nor expenses paid for participation in the test*[.]" (Emphasis supplied).

Finally, we note that the form claimant signed prior to taking the physical abilities test released the employer from liability for injuries during the testing. This release also put claimant on notice that the test was for future employment and did not concern previously authorized temporary employment.

Under these circumstances, we are not persuaded that claimant was acting within the course and scope of her employment relationship when she participated in the physical abilities test. Consequently, we affirm the ALJ's conclusion that the insured was not claimant's employer at the time of her injury.

ORDER

The ALJ's order dated June 26, 1998 is affirmed.

December 17, 1998 Cite as 50 Van Natta 2361 (1998)

In the Matter of the Compensation of
BRANDI L. NEWMAN, Claimant
WCB Case No. 98-01837
ORDER DENYING RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our November 27, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of claimant's head injury claim. In our order, we first found it unnecessary to decide whether the ALJ erred in refusing to admit certain testimony from a witness. Furthermore, in coming to our conclusion, we found the evidence in equipoise concerning whether claimant slipped before falling or fainted before falling. Thus, we concluded that claimant did not carry her burden of proving that her head injury "arose" out of her employment.

In asking for abatement and reconsideration, claimant "suggests the Board must rule on the admissability [sic] of * * * testimony before stating the evidence rests in equipoise" and further "suggests the Board erred as a matter of fact in finding [two witnesses] equally credible and persuasive witnesses."

We find that, because claimant essentially raises the same arguments that we addressed in our order, abatement and reconsideration is not necessary. Accordingly, we deny claimant's motion and we adhere to our November 27, 1998 order. The parties' rights of appeal shall continue to run from the date of that order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOROTHY DICKINSON, Claimant
WCB Case No. 97-07047
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests, and claimant cross-requests, review of that portion of Administrative Law Judge (ALJ) Herman's order that awarded a $9,500 attorney fee. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant's counsel requested a $12,000 assessed attorney fee for 61 hours of legal services at the hearings level. The employer objected to the amount of the fee requested, contending that it was excessive.

The ALJ awarded a $9,500 attorney fee for claimant's counsel's "significant legal work." The ALJ noted that claimant's counsel's efforts included: obtaining a pre-hearing medical report; participating in the hearing and post-hearing arguments; obtaining a rebuttal medical report; attending three medical experts' depositions; and participating in telephonic closing arguments. The ALJ also found the case medically complex, both attorneys to be highly skilled, and the value of the claim and benefits obtained significant.

On review, the employer argues that the attorney fee award was excessive. Claimant responds that the fee should be increased to $12,000 because of the medical complexity of the case, the time spent, the value of claimant's interest and the benefit secured, the attorneys' skills, and the risk that claimant's counsel might have gone uncompensated. Claimant's counsel also submits a statement of services attesting to 67 hours of legal services.

We first find that the ALJ's explanation for the fee award sufficiently complied with the Supreme Court's instruction in *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997)[1], because the hearings record contains only a general attorney fee request and no argument as to how the rule-based factors should be weighed in determining a reasonable fee. *See Russell L. Martin*, 50 Van Natta 313 (1998).

Nonetheless, we review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of 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.

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[1] Under *Schoch*, we are required to set forth a "rational connection" between consideration of the rule-based factors and the fee awarded.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. The employer denied the claim in August 1997. Claimant retained her attorney soon thereafter and the attorney promptly filed a hearing request.

Approximately 14 exhibits were received into evidence (totaling over 270 pages of evidence, including 26 pages of medical journal articles), with at least 3 important medical reports submitted by claimant. The record also includes three medical experts' depositions (held on three separate days), with transcripts of 86 pages (lasting 2 hours and 40 minutes), 63 pages, and 53 pages (lasting one hour and 26 minutes). The hearing was held on 2 days (November 25, 1997 and June 9, 1998),[2] and lasted about three hours with a transcript consisting of approximately 100 pages. Claimant was the only witness who testified. Closing arguments lasted about another 1 1/2 hours.

During closing arguments, claimant's counsel attested that she had spent 61.7 hours on the case. (*See* Opinion and Order, p. 6). On review, claimant submits a detailed statement of services, showing 61.7 hours of legal services through the hearing and an additional 5.3 hours of services related to closing arguments, post-hearing conferences, and communications with claimant and the employer's counsel.[3]

The case involved issues of above average medical complexity, considering the range of cases generally submitted to this forum (*i.e.*, an occupational disease claim for carpal tunnel syndrome, with medical evidence forcefully disputing causation). The claim's value and the benefits secured are also above average, because substantial medical services (including bilateral surgery) are involved. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous defense.[4]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $7,500 is a reasonable attorney fee for services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and evaluating claimant's counsel's submission in light of the employer's objection), the medical complexity of the issue, the value of the interest involved, the nature of the proceeding (including three depositions), and the risk that claimant's counsel might go uncompensated. Finally, we note that claimant is not entitled to an attorney fee for services related to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 9, 1998 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, claimant is awarded a $7,500 assessed attorney fee, to be paid by the self-insured employer. The remainder of the order is affirmed.

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[2] Travel to the hearing and depositions was apparently limited to the Portland metropolitan area.

[3] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

[4] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the medical complexity of the issue, the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

In the Matter of the Compensation of
TED L. GOLDEN, Claimant
WCB Case Nos. 98-01162 & 97-06378
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's "de facto" denial and its October 3, 1997 current condition denial. The employer cross-requests review of that portion of the order that affirmed an Order on Reconsideration that awarded 8 percent (25.6 degrees) unscheduled permanent disability for a low back condition. On review, the issues are compensability and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In October 1996, claimant twice injured his low back at work. Dr. Bachman, chiropractor, diagnosed a lumbosacral disc injury with associated lumbar and sacroiliac subluxation and muscle spasm. (Ex. 8). X-rays revealed six lumbar vertebrae of congenital origin, degenerative change in the lower lumbar discs, and long-standing minor wedging of L1. (Ex. 2). In December 1996, claimant reinjured his back at work. He was diagnosed with a lumbosacral strain. (Ex. 16). A CT scan showed an increased lordotic curve, some facet disease at multiple levels, most marked at L6-S1, early degenerative instability and anterolisthesis of L6 on S1. No disc herniation or abnormalities were noted. (Exs. 29, 34-2, -3). Dr. Peterson, claimant's attending physician, diagnosed degenerative changes in the lumbosacral spine with pain after lumbosacral strain. (Ex. 27). The employer accepted a lumbar strain. (Ex. 29).

In February 1997, claimant was examined for the employer by Drs. Rich, neurologist, and Marble, orthopedic surgeon. They diagnosed a lumbosacral strain that combined with the preexisting congenital segmentation error and possible spondylolisthesis to produce symptoms and a possible objective worsening. (Ex. 34).

Dr. Zimmerman, neurosurgeon, diagnosed a grade I spondylotic spondylolisthesis without significant spinal cord compression. (Ex. 37). Claimant's back continued to worsen. In June 1997, Zimmerman requested surgery. (Ex. 43).

On July 1, 1997, claimant requested acceptance of congenital abnormality including a segmentation error at L6-S1, lumbar degenerative instability and spondylolisthesis of the low back, pursuant to ORS 656.262(6)(d). (Ex. 45A). The employer did not respond. Claimant filed a hearing request on August 5, 1997, challenging the notice of acceptance and alleging a "de facto" denial.

On October 3, 1997, the employer denied compensability of claimant's current low back condition on the basis that his injury had ceased to be the major cause of the need for treatment of his combined condition. (Ex. 24). Claimant filed a request for hearing on the current condition denial.

On October 17, 1997, the employer issued a Notice of Closure that awarded no permanent disability. (Ex. 51). Claimant requested reconsideration and was examined by an arbiter, Dr. Hunt. (Ex. 55). A January 26, 1998 Order on Reconsideration awarded 8 percent unscheduled permanent disability. (Ex. 57). The employer filed a request for hearing to challenge the Order on Reconsideration.

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation to address claimant's arguments on review.

Claimant contends that the ALJ erred in determining that the employer's October 3, 1997 partial denial was procedurally proper because the employer did not accept a combined condition, citing to *Michael Leggett*, 50 Van Natta 51 (1998); *Elizabeth Bernsten*, 48 Van Natta 1223 (1996); and *Robin Spivey*, 48 Van Natta 2363 (1996). The employer argues that, because claimant raised the procedurally improper denial issue for the first time on review, we should not consider it. We agree for the following reasons.

The scope of our de novo review encompasses all issues considered by the ALJ. *See Destael v. Nicolai*, 80 Or App 723 (1986); *see also* OAR 438-006-0031. The ALJ, however, did not address the procedural propriety of the denial at hearing. Moreover, the record does not show that the procedural issue was raised in claimant's specification of issues. Moreover, claimant's position at hearing was that the current condition denial was not supported medically and factually, arguments directed to the merits. (Tr. 5, 6). Because claimant did not raise the propriety of the current condition denial issue at hearing, we decline to address that issue on review. *See Kenneth L. Devi*, 48 Van Natta 2349 (1996), *on recon* 49 Van Natta 108 (1997) (declining to consider claim preclusion issue not raised at hearing or until closing argument, at the earliest); *Janice A. Talevich*, 48 Van Natta 2318, 2319 (1996) (declining to consider "back-up" denial issue raised for first time on review).[1]

Claimant also contends that the scope of his accepted conditions should include segmentation error at L6-S1, lumbar degenerative instability, and spondylolisthesis of the low back. To the extent that claimant is asserting that the preexisting conditions should be accepted as combined conditions, then the ALJ's analysis would apply. To the extent that claimant's argument means that he has suffered a compensable segmentation error at L6-S1, lumbar degenerative instability, and spondylolisthesis separate from the lumbar strain that was accepted by the employer, then he must establish the independent compensability of those conditions.

Claimant relies on the initial medical report from Drs. Rich and Marble to establish the compensability of his preexisting conditions. Claimant's reliance is misplaced. The doctors indicated that claimant's lumbar strain "could have" caused a worsening of the preexisting conditions or that it "may have" combined with the congenital abnormality to produce a change and worsening. (Ex. 34-6). The word "could have" and "may have" indicate only possibility, not medical probability, which is insufficient to carry claimant's burden of proof. *Gormley v. SAIF*, 52 Or App 1055 (1981).

In addition, claimant's reliance on Dr. Peterson's last report is also misplaced. Dr. Peterson indicated that claimant had a congenital segmentation error that resulted in degenerative changes with chronic pain after injury that required surgical intervention. (Ex. 60). Dr. Peterson did not state that the injury was the major cause of the combined condition or need for medical treatment. Rather, he stated that claimant's preexisting conditions put him at a high risk of back problems, and under the appropriate circumstances back pain was inevitable. (Ex. 60-2). Dr. Peterson's comments regarding claimant's preexisting conditions are insufficient to establish that claimant's injury was the major contributing cause of his conditions and need for medical treatment, particularly in light of the preponderance of persuasive medical opinions stating that claimant's preexisting conditions were not caused by the injury and that the major contributing cause of claimant's need for treatment is the preexisting conditions.

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's opinion on this issue with the following supplementation to address the employer's arguments on review.

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[1] Moreover, were the issue before us, we would uphold the denial as procedurally proper. We recently revisited the "pre-closure" denial case law in *Tracey A. Blamires*, 50 Van Natta 1793 (1998), *on recon* 50 Van Natta 2273 (1998). In that case, we disavowed *Spivey* and its progeny to the extent that those cases held that ORS 656.262(7)(b) applies only if the carrier has expressly accepted a combined condition. We concluded 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 carrier may avail itself of the "pre-closure" denial procedure in ORS 656.262(7)(b). In other words, 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. Accordingly, because the employer's October 1997 denial in the present case was issued under such circumstances, we would find it procedurally appropriate.

The ALJ affirmed the Order on Reconsideration's unscheduled permanent disability award of 8 percent. The employer contends that claimant's impairment is more likely due to his preexisting conditions or his subsequent motor vehicle accident than to the accepted lumbar strain. We do not agree.

As discussed by the ALJ, the arbiter properly evaluated impairment due to the compensable condition, the preexisting conditions and the MVA, concluding that 25 percent of claimant's impairment was due to the compensable injury. (Ex. 55). Accordingly, after reviewing the reconsideration record and the applicable standards, we agree with the Order on Reconsideration's impairment findings of 2 percent due to reduced lumbar range of motion.[2]

The employer also contends that the arbiter's report should not be relied on regarding claimant's residual functional capacity (RFC), as it is speculative and theoretical, and does not establish whether the loss of RFC was due to the compensable condition or the preexisting condition and/or the MVA, as required under OAR 436-035-0007(2)(b).

We find that OAR 436-035-0007(2)(b) is inapplicable in this case. That rule applies to workers with superimposed conditions as long as the compensable condition is medically stationary and remains the major contributing cause of the overall condition. Here, the compensable condition does not remain the major contributing cause of the overall condition. Thus, the applicable rule is OAR 436-035-0007(4)(d)(B).[3]

In accordance with the rule, the arbiter appropriately estimated the restrictions on claimant's lifting, bending and twisting, indicating that these were permanent restrictions. Therefore, the Director's standards were correctly applied at reconsideration to result in a value of 3.

ORDER

The ALJ's order dated June 11, 1998 is affirmed.

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[2] The employer's contention that the arbiter's *impairment findings* were purely speculative is misplaced. The arbiter stated that his estimate of claimant's *residual functional capacities* is speculative in light of claimant's MVA and the lack of physical capacities testing prior to the MVA.

[3] OAR 436-035-0007(4)(d)(B) provides:

"If the compensable condition is no longer the major contributing cause of the combined or superimposed condition, and a major contributing cause denial has been issued, the following applies:

"* * * * *

"To estimate an adaptability factor when the unscheduled compensable condition is to the shoulder, hip, spine, pelvis or abdomen, the physician shall estimate the worker's future likely residual functional capacity pursuant to OAR 436-035-0310(3)(c) through (o), that would be due only to the compensable condition at the anticipated time of medically stationary status. Only the portion due to the compensable condition at the time of medically stationary status shall receive a value."

In the Matter of the Compensation of
JAKE E. GRILE, Claimant
WCB Case No. 97-08350
ORDER ON REVIEW
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Brazeau's order that determined that a Disputed Claim Settlement (DCS) and a Claim Disposition Agreement (CDA) were valid. On review, the issue is the validity and effect of the DCS and CDA.

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

The ALJ determined that claimant's right to compensation was extinguished with regard to a an L4-5 disc condition and carpal tunnel syndrome. In making this determination, the ALJ noted that claimant had withdrawn his request for hearing regarding the carpal tunnel condition during proceedings before a prior ALJ. In addition, the prior ALJ had upheld the self-insured employer's denial of the L4-5 disc condition, a decision that was affirmed by an unappealed Board order. *Jack C. Grile*, 45 Van Natta 983 (1993). The ALJ also concluded that claimant's right to compensation for a compensable L3-4 disc condition was "forever extinguished" through the combined effect of a DCS and CDA, except for medical services related to the compensable injury. Finally, the ALJ rejected claimant's contention that the settlements should not be given effect, finding no evidence that claimant was incompetent or otherwise mentally impaired when he signed the settlement agreements.

We agree with the ALJ that claimant has no right to compensation for the L4-5 disc condition and carpal tunnel syndrome because of our prior final order upholding the employer's denial of the L4-5 disc conditon and claimant's withdrawal of his hearing request pertaining to the carpal tunnel condition. We clarify, however, claimant's rights to compensation for the compensable L3-4 condition.

The DCS provides that claimant sustained a compensable injury at the L3-4 level on April 25, 1990. (Ex. 77-1). The DCS further provides that claimant's "current disability and need for medical treatment" for this condition were denied and that the DCS involved claimant's "current need for medical treatment and disability." Although claimant agreed, in exchange for the sum of $35,000, that the employer's contentions in the DCS would constitute the "law of the case," the agreement specifically noted that claimant retained all rights that may later arise under ORS 656.245, 656.273, 656.278 and 656.340, insofar as those rights may be related to the original accepted claim of a herniated disc at L3-4. (Ex. 77-5).

Accordingly, under terms of the DCS, claimant retained rights to compensation with respect to the original compensable injury at L3-4. Granted, claimant and the employer agreed to a CDA whereby, in exchange for the sum of $35,000, claimant released all rights to benefits for the accepted L3-4 herniated disc, except for medical services. (Ex. 79). The fact remains, however, that, under the DCS and CDA, claimant does retain rights to medical services for the L3-4 disc condition to the extent that they are related to the original compensable injury. In this respect, we clarify the ALJ's statement that claimant's entitlement to compensation for the L3-4 disc condition was "forever extinguished" by the combined effect of the DCS and CDA, except for medical services related to the compensable injury.

Finally, we find no "extreme circumstances" that justify setting aside the DCS negotiated by claimant's former counsel and that provided claimant a total of $70,000 in exchange for claimant's release of most--but not all--rights under the compensable claim for the L3-4 disc condition. *See Floyd D. Gatchell*, 48 Van Natta 467 (1996) (setting aside an approved disputed claim settlement is an extraordinary remedy to be granted sparingly in the most extreme circumstances). There is no evidence that claimant's attorney failed to inform claimant of the affect of the settlement, nor is there evidence that claimant was incapable of understanding the meaning of this document. Moreover, we approved the CDA in a final order pursuant to ORS 656.236, which is not subject to further review. ORS 656.236(2). In any event, such an order would not issue if we found that agreement unreasonable as a matter of law, or based on an intentional misrepresentation of material fact, or if claimant had requested that the Board disapprove the agreement within 30 days from the date it was submitted to the Board. ORS 656.236(1).

ORDER

The ALJ's order dated July 31, 1998 is affirmed.

December 17, 1998 Cite as 50 Van Natta 2368 (1998)

In the Matter of the Compensation of
ELLEN E. HANCOCK, Claimant
WCB Case No. 98-01495
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) declined to admit certain exhibits; (2) upheld the self-insured employer's denial of her aggravation claim for a bilateral wrist condition; and (3) declined to award a penalty. On review, the issues are evidence, aggravation and penalties and attorney fees.

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

Claimant contends that the ALJ erred in excluding Exhibit 36, an appellate brief filed by the employer in a prior "extent" proceeding involving claimant's initial claim. We find to the contrary.

Pursuant to ORS 656.283(7), an 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. Further, the ALJ has broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). Consequently, 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).

Here, we find no abuse of discretion in the ALJ's decision to exclude Exhibit 36. The proffered document contains legal argument challenging the propriety of a prior ALJ's order. The employer's legal arguments do not constitute "evidence" of claimant's compensable condition, its alleged worsening or the reasonableness of the employer's aggravation denial.[1] We therefore agree with the ALJ that Exhibit 36 is not relevant. We note, however, that even if we were to consider the exhibit on review, it would not affect the outcome of this case.

ORDER

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

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[1] To the extent that claimant's argument could be interpreted to assert the doctrine of *judicial estoppel*, that doctrine is inapplicable here because the employer's argument in the extent case was unsuccessful. *See Hampton Tree Farms, Inc. v. Jewett*, 320 Or 599, 609-10 (1995).

In the Matter of the Compensation of
BRENT L. MARLATT, Claimant
WCB Case No. 98-03197
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) held that the self-insured employer properly reduced claimant's pay to his temporary partial disability (TPD) rate as of April 9, 1998, the date claimant refused the employer's new light duty job offer; and (2) declined to assess a penalty and related attorney fee for the employer's allegedly unreasonable claims processing. On review, the issues are temporary disability, penalties and attorney fees.

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

We begin with a summary of the relevant facts. Claimant has an accepted right shoulder injury claim. At the time of injury, claimant worked the swing shift, which was from 4:00 p.m. to 12:30 a.m.. For a period of time, claimant was released from work due to the work injury. On March 13, 1998, Dr. Butler, claimant's treating physician, released claimant to light duty work with several restrictions on lifting. Subsequently, the employer offered and claimant accepted a light duty position that was within Dr. Butler's restrictions. This light duty position was on the swing shift and paid less than claimant's regular wage. While claimant worked in this light duty position, the employer paid him TPD to make up the difference between the light duty wage and claimant's temporary total disability (TTD) rate.

Subsequently, the employer changed the terms of its light duty employment and assigned all of its employees who were limited to light duty to the "Wellness Center," a job that was only available during the "regular shift," *i.e.*, from 7:00 a.m. to 3:00 p.m.. Dr. Butler approved that light duty job. On April 9, 1998, when claimant became aware of the change in the light duty job, he requested to continue working at light duty work during the swing shift and refused to accept the new light duty job. (Ex. 28). The sole reason for claimant's refusal was that his child care arrangements interfered with his ability to work during the "regular shift" because his wife also worked during that shift, which would necessitate obtaining child care, an option that claimant found economically unfeasible. (Tr. 14-16). When claimant refused the new light work job, the employer stopped paying his wages but continued paying him the TPD benefits he would have received if he had accepted the new light duty job. Claimant requested a hearing.

At hearing, claimant argued, in part, that, given his child care circumstances, the change of shift in the new light duty job offer was unreasonable, and the employer should have commenced payment of TTD benefits when it no longer offered him a light duty position on the swing shift. Relying on *Glenda Jensen*, 50 Van Natta 571, *on recon* 50 Van Natta 1074 (1998), the ALJ rejected claimant's arguments.

On review, noting that our decision in *Jensen* has been appealed and is now pending at the Court of Appeals for a decision, claimant requests that we stay further proceedings until the court reviews the temporary disability issue decided in *Jensen*. The employer opposes claimant's request.

In the absence of the parties' agreement to do otherwise, we decline to hold a matter in abeyance indefinitely pending resolution of a court appeal in another case. *See Linda J. (Smith) Collins*, 50 Van Natta 432 (1998); *Yvette A. Allen*, 49 Van Natta 1246 (1997); *Carl L. Gruenberg*, 49 Van Natta 750 (1997). Turning to the merits of the temporary disability issue, we agree with the ALJ that *Jensen* controls the outcome of this case.

In *Jensen*, the claimant refused a modified job offer approved by her attending physician because the shift offered conflicted with the claimant's child care arrangements. Specifically, the claimant's husband (due to his work schedule) would not be able to watch their children during some of the offered shift. The claimant asked if she could accept the position at a different shift and was told that it was not possible. Based on the claimant's refusal of the employer's job offer, the insurer terminated TTD benefits.

We found that the employer had complied with all of the statutory and regulatory requirements for terminating TTD benefits. ORS 656.268(3)(c); OAR 436-60-030(12).[1] Specifically, we reasoned that the employer had offered the claimant a modified job that was within her physical capabilities and had been approved by her attending physician, and the claimant had refused the offer. Therefore, we found that the insurer was authorized to terminate TTD benefits pursuant to ORS 656.268(3)(c). While we understood that the claimant had legitimate family needs that outweighed her interest in accepting the available modified employment, we found that her decision represented a personal choice based on considerations that were outside the parameters of the statute and rules authorizing termination of TTD benefits. We concluded that neither the statutes nor rules require an employer to offer modified work at the same work shift as the job at injury.

The same reasoning applies here. The fact that claimant was working at a modified job and was being paid TPD benefits when he refused the changed light duty job offer does not change the result. Because the employer complied with ORS 656.268(3)(c) and OAR 436-060-0030(5), it was entitled to continue paying TPD benefits after claimant refused the changed light duty job offer.[2] The employer was not required to offer modified work at the same work shift as the job at injury, nor was it required to begin paying TTD benefits when claimant refused the changed modified job offer.

ORDER

The ALJ's order dated August 7, 1998 is affirmed.

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[1] Although the language of this rule remains the same, the applicable rule has since been renumbered as OAR 436-060-0030(5). (WCD Admin. Order 96-070, eff. November 27, 1996).

[2] We note that OAR 436-060-0030(8) provides that TPD shall be paid at the full TTD rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. Under the facts of this case, we do not find that the employer "withdrew" the modified job offer by offering claimant a modified job on a different shift than claimant's at-injury shift. The modified job remained available and had been approved by claimant's physician. Claimant's decision not to accept the modified job offer was a personal choice based on considerations outside the parameters of the Workers' Compensation Law.

In the Matter of the Compensation of
SHAWNA L. TAPPE, Claimant
WCB Case Nos. 98-01207 & 97-07651
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Martha J. Brown's order that upheld the insurer's denial of her injury claim for a left arm condition. On review, the issue is compensability and (potentially) responsibility.

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

The ALJ upheld the insurer's denial, finding that claimant had failed to sustain her burden of proving that a October 7, 1996 work incident was a material contributing cause of her left upper extremity condition. In doing so, the ALJ found the opinion of Dr. Puziss, claimant's current attending physician, unpersuasive when he concluded that the October 7, 1996 incident caused claimant's ulnar nerve condition.

On review, claimant contends that the ALJ should have deferred to Dr. Puziss' opinion and found that she sustained her burden of proving compensability. We disagree.

Apart from the reasons the ALJ cited for discounting Dr. Puziss's opinion, we note that a prior attending physician, Dr. Buehler, agreed with a medical report submitted by Dr. Nathan, an examining physician. (Ex. 43). Dr. Nathan concluded that the October 1996 incident did not cause claimant's left ulnar nerve neuropathy. (Ex. 42-7). In light of Dr. Buehler's concurrence with the Nathan report, we

agree with the ALJ that a preponderance of the medical evidence does not support a material causal connection between the October 1996 incident and claimant's left arm condition. Accordingly, we agree with the ALJ's decision to uphold the insurer's denial.

ORDER

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

December 17, 1998 Cite as 50 Van Natta 2371 (1998)

In the Matter of the Compensation of
RICHARD R. MERRIMAN, Claimant
WCB Case No. 98-03351
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Bock, Biehl, and Moller.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) determined that it "waived" appearance by failing to appear at the hearing; (2) directed the employer to resume payment of temporary disability; and (3) awarded a 25 percent penalty for the employer's allegedly unreasonable claim processing. In support of a motion for remand, the employer has submitted "post-hearing" documentary evidence pertaining to the reasons for its failure to appear at hearing and to the merits of the temporary disability issue. On review, the issues are remand, hearing procedure, temporary disability, penalties and attorney fees. We deny the motion for remand and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury in November 1997, accepted as a disabling lumbar strain. On March 10, 1998, claimant's attorney wrote the employer's claim processing agent, self-insured management services (SIMS), stating that temporary disability payments were being withheld and requesting that they be reinstated. (Ex. 6). On April 21, 1998, claimant's counsel again requested that temporary disability payments be resumed and enclosed a copy of a request for hearing on the issue. (Ex. 9).

In his hearing request, claimant sought temporary disability ongoing from January 1998, as well as penalties and attorney fees. The hearing request also contained a motion for expedited remedy for the alleged failure to pay temporary disability. On May 11, 1998, an Order to Show Cause For Failure to Pay Compensation was issued and mailed to both the employer and SIMS (neither the employer's nor SIM's copies of this order were returned to the Hearings division as undeliverable). The order provided that the carrier was required to show cause within 15 days of the order about why temporary disability had not been continued. The order further stated that a hearing "shall be held, if necessary" on May 27, 1998 before an ALJ.

A hearing was convened on May 27, 1998. Claimant and his counsel were present, but neither the employer nor SIMS appeared at the hearing. The ALJ found that the employer had "waived" appearance under OAR 438-006-0071(2) and proceeded to determine the merits of the temporary disability, penalty and attorney fee issues. Concluding that the employer had failed to comply with the requirements of ORS 656.268(3) for termination of temporary disability, the ALJ held that claimant was entitled to resumption of the payment of temporary disability. Moreover, the ALJ determined that the employer's termination of temporary disability was unreasonable, thereby entitling claimant to a 25 percent penalty.

On review, the employer moves for remand to the ALJ for consideration of "post-hearing" documentary evidence on the ground that the record had been improperly, incompletely and insufficiently developed. The employer also requests the case be remanded for consideration of a "post-

hearing" motion for postponement. Alternatively, if the motion for remand is not granted, the employer asserts that claimant failed to prove entitlement to temporary disability based on the record developed before the ALJ. For the following reasons, we deny the motion for remand and agree with the ALJ's determination of the issues.

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

In this case, the employer failed to attend the May 27, 1998 hearing. The issue then becomes whether that failure to attend was "unjustified" and, therefore, constitutes a waiver of appearance. The ALJ determined that the employer's failure to attend the hearing was unjustified. The ALJ noted that 15 days had passed since issuance of the May 11, 1998 show-cause order that was mailed to the last known address of SIMS and had not been returned to the Hearings Division by the postal service. (Tr. 2).

The employer has submitted as part of its motion for remand an affidavit from a supervisor (Dodge) at SIMS who states that the show cause order, which he concedes was received by SIMS on May 12, 1998, was misfiled and issued at a time when a change of supervisors and transfer of claimant's file had occurred. Dodge avers that, had the order not been misfiled, he would have seen the show-cause order and arranged for legal representation at the May 27, 1998 hearing. Dodge also states that no exhibits were received from claimant's attorney and that the language of the show-cause order was ambiguous regarding the necessity of a hearing. Alleging that the employer did not waive appearance at the hearing, Dodge asserts that extraordinary circumstances justify postponement of the hearing.

Based on the circumstances existing at the time the ALJ determined that the employer's failure to appear was unjustified, we agree with the finding that the employer had "waived" appearance at the hearing. Obviously, the ALJ did not have knowledge of the alleged justification that the employer has now submitted. Because our review of the record is limited to that developed before the ALJ, we must determine whether a remand is necessary for consideration of the employer's affidavit.

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).

In this case, we find no compelling reason to remand for consideration of the information contained in the affidavit of Dodge. Specifically, we find that it is not reasonably likely to affect the outcome of the case because the justification contained in the affidavit is not sufficient to excuse the employer's failure to appear at the show-cause hearing. SIMS concedes that it received the show-cause order on May 12, 1998. However, due to a combination of misfiling and internal procedures, the show-cause order was not discovered in time for SIMS to arrange legal representation at the May 27, 1998 hearing. Inasmuch as SIMS is retained by the employer to process its workers' compensation claims, it is responsible for properly administering the claim and for the consequences of internal mis-handling of a file. Therefore, we find that evidence supporting the employer's motion for remand is unlikely to affect the outcome of the issue of whether its failure at appear at hearing was justified. Thus, we decline to remand to the ALJ for submission of additional evidence on this issue.[1]

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[1] Relying on dictionary definitions of "unjustified" and "justify," the dissent contends that the employer's failure to appear at the show-cause hearing was justified. The dissent's contentions notwithstanding, SIMS is responsible for the proper administration of claims it was retained to process. Thus, we are persuaded that its failure to appear at the May 27, 1998 hearing was "unwarranted in light of the surrounding circumstances." Moreover, we do not believe the dissent's citation to *Brown v. EBI*, 289 Or 455 (1980) requires a different result. *Brown* concerned the "good cause" standard contained in ORS 656.319 for untimely hearing requests. In contrast, here we are concerned with the issue of whether the employer waived its appearance at the show-cause hearing by unjustifiably failing to attend the hearing. Had OAR 438-006-0071(2) been intended to incorporate the "good cause" standard discussed in *Brown*, it could have done so by directly stating that was applicable standard. The rule, however,

The employer notes that we have often remanded to an ALJ to consider a "post-order" request for postponement. *See e.g. Jenny S. Debelloy*, 49 Van Natta 134 (1997). The employer argues that we should do so in this case as well. However, what distinguishes this case from those in which we have remanded for consideration of a "post-order" request for postponement is that in this case the party requesting postponement (the employer) is not the party that requested the hearing.

OAR 438-006-0071(2) states that an ALJ shall dismiss a hearing request if the party that has "waived" appearance is the party that requested the hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. Thus, the rule only contemplates the possibility of postponement or continuance for the party that requested the hearing. Because the employer is not the party that requested the hearing in this matter, no postponement option is available to the employer.[2] Accordingly, the dispositive issue is whether the employer's failure to attend the hearing was unjustified. If not, the ALJ correctly proceeded to determine the merits of the issues raised by claimant based on the record as developed. Because we agree with the ALJ's determination that the employer's failure to appear at the hearing was unjustified, we must next address the ALJ's determination that the employer improperly terminated temporary disability pursuant to ORS 656.268(3).[3]

The employer contends that, based on the evidence admitted at the May 27, 1998 show-cause hearing, it properly terminated claimant's temporary disability. It asserts that this evidence establishes that claimant was released for regular work at the time his temporary disability was terminated. See ORS 656.268(3)(b). We disagree. Based on our *de novo* review of the record, we find no grounds for termination of claimant's temporary disability.[4] Claimant was never released for regular work nor did

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does not do so. Therefore, we are not persuaded by the dissent's argument that the employer's conduct should be excused by a file clerk's mishandling of the hearing notice. Finally, *Brown* states that it is within our discretion to find "good cause" when a default is caused by the mistake or neglect of an employee who is not charged with responsibility for recognizing and correctly handling a legal notice. 289 Or at 460. Even assuming that the *Brown* standard is applicable to this case, we would still conclude that "good cause" has not been established when the employer's failure to appear was the result of internal mishandling of a file.

[2] The employer asserts that such a result will deny it "substantial justice." We disagree. "Substantial justice" does not require that the employer obtain the opportunity to present evidence that it could have presented at hearing had it appeared. In other words, the employer did not receive notice of the expedited hearing by reason of its own internal procedures. This does not mean that claimant's request for relief must be delayed to allow the employer to present evidence that it previously had the opportunity to present had it appeared at the hearing for which it undeniably had notice.

[3] 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."

[4] As previously noted, the employer has submitted "post-order" documentary evidence on the termination of temporary disability issue, including a July 22, 1998 medical report from Dr. Hoppert, a November 30, 1998 concurrence report from Dr. King and a December 1, 1998 concurrence report from Dr. Hoppert. We interpret the employer's submission as a motion for remand. We deny the motion because we are not persuaded that the proffered evidence was unobtainable with the exercise of due diligence prior to hearing. In other words, but for its unjustified failure to appear at the hearing, the employer could have presented this or similar evidence at the show-cause hearing.

he ever return to regular work. We also do not find evidence to support termination pursuant to ORS 656.268(3)(d).[5]

Finally, we do not find that the record as developed provides "legitimate doubt" for the termination of temporary disability. *See Brown v. Argonaut Insurance Co.*, 93 Or App 588, 591 (1988). Accordingly, we conclude that the ALJ correctly assessed a penalty for the employer's unreasonable claim processing.

Because we have not reduced or disallowed claimant's compensation, claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review 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 issues, and the value of the interest involved. We have not considered claimant's counsel's services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

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

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[5] Citing *Daral T. Morrow*, 48 Van Natta 497 (1996), the employer argues that claimant's attending physician ceased to authorize temporary disability pursuant to ORS 656.262(4)(g). In *Morrow*, we found that the date of the claimant's treating physician's letter stating that it was too difficult to authorize a release from work due to the compensable injury established the date the treating physician "ceased" to authorize temporary disability. In this case, however, the record does not contain a letter similar to that the attending physician submitted in *Morrow*. Thus, we do not find sufficient evidence that an attending physician "ceased" to authorize temporary disability.

Board Member Moller dissenting.

The majority declines to remand this case to the ALJ for consideration of Dodge's affidavit because it concludes that the information it contains is not reasonably likely to affect the outcome of the case. In so doing, the majority finds that the employer's failure to attend the show-cause hearing was "unjustified" based on the reasons given in Dodge's affidavit. Because I would find that the employer's failure to appear at hearing was justified (or at least the reasons given in Dodge's affidavit are reasonably likely to affect the outcome of the case), I would remand to the ALJ. I reason as follows.

The majority does not explain the legal standard used to determine whether failure to appear at hearing is "unjustified." Because the administrative rule does not contain a definition of "unjustified," it is appropriate to consult other sources to clarify the legal standard. *See Bradley R. Kubik*, 50 Van Natta 989 (1998) (consulting dictionary where no guidance provided in Director's rule regarding definition of relevant terminology).

Webster's Third International Dictionary defines "unjustified" as "not demonstrably correct or judicious; unwarranted in light of the surrounding circumstances." Webster's II New Riverside University Dictionary defines "justify" in a legal context as meaning "to show good reason for (an action taken)." Regardless of which standard is applied (whether the employer's failure to appear was "unwarranted in light of the surrounding circumstances" or whether the employer lacked "good reason," *i.e.*, "good cause" for its non-appearance), I believe that the employer did not waive appearance under OAR 438-006-0071(2).

First, unlike the standard hearing notice, which provides the parties with 90 days advance notice of a hearing, the employer, here, was provided only 16 days advance notice of the show-cause hearing, because of the expedited nature of the proceeding. Moreover, advance notice by means of exhibit exchange did not occur as it does in the usual case.

Second, the employer received a document entitled "Order to Show Cause For Failure to Pay Compensation." It stated that a hearing would be held "if necessary" on May 27, 1998. Unlike the majority, I find the wording of the show- cause order to be ambiguous in that it was not clear that a hearing would, in fact, be necessary.

Third, Dodge averred that issuance of the show-cause order occurred when a change of supervisors and transfer of claimant's file had taken place. More importantly, it appears that a file clerk not charged with responsibility for recognizing the legal importance of a show-cause order misfiled the show-cause order. This directly led, according to the Dodge affidavit, to the employer's failure to timely retain counsel for the show-cause hearing.

Accordingly, I would find that the circumstances, in total, refute a finding that failure to appear was "unwarranted in light of surrounding circumstances." Indeed, the action of a file clerk mishandling the show-cause order is "good cause" under legal precedent and should excuse the employer's failure to appear at the show-cause hearing. *See Brown v. EBI*, 289 Or 455, 460 (1980) (in determining "good cause" under ORS 656.319(1)(b), it is at least within the range of agency discretion to relieve a claimant from a default caused by the mistake or neglect of an employee who is not charged with responsibility for recognizing and correctly handling the message that constitutes the legally crucial notice from which the time to respond is measured).

To sum up, Dodge's affidavit provides ample reason to remand this case to the ALJ for a determination of whether the employer's failure to attend the show cause hearing was justified. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
MICHAEL D. RIORDAN, Claimant
WCB Case No. 97-04095
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its partial denial of claimant's consequential depressive condition; (2) set aside its "pre-closure" current condition denial; and (3) awarded claimant's attorney an assessed attorney fee for his services in setting aside the pre-closure denial. On review, the issues are compensability, claim processing and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant has an accepted claim for exposure to carbon monoxide (CO). Immediately following that exposure, claimant reported cognitive deficits, and he subsequently developed a depressive condition. On March 20, 1997, SAIF issued a denial of the depressive condition. On May 19, 1997, SAIF issued a "pre-closure" current condition denial.

CONCLUSIONS OF LAW AND OPINION

Partial Denial of Depression

We adopt and affirm the ALJ's decision that claimant's depressive disorder is a compensable consequence of his accepted toxic exposure.

"Pre-closure" Current Condition Denial

Prior to the closure of claimant's toxic exposure claim, SAIF issued a denial on the ground that: claimant's current condition was attributable to a combination of a preexisting depressive disorder and the toxic exposure; and the compensable injury was no longer the major contributing cause of the current combined condition. The ALJ concluded that SAIF's "pre-closure" current condition denial was procedurally invalid under ORS 656.262(7)(b), which provides in pertinent part:

> "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

In concluding that SAIF's denial was procedurally invalid, the ALJ relied on *Elaine M. Borgelt*, 50 Van Natta 143 (1998) and *Elizabeth B. Berntsen*, 48 Van Natta 1219 (1996). In *Borgelt* and *Berntsen* we reasoned that, absent an acceptance of a combined condition, a carrier did not have authority under ORS 656.262(7)(b) to issue a "pre-closure" denial on the ground that an otherwise compensable injury was no longer the major contributing cause of a claimant's current combined condition. On review, SAIF challenges this rationale and argues that its denial is authorized under ORS 656.262(7)(b) because the medical evidence establishes that claimant's compensable injury combined with a preexisting condition. We affirm the ALJ's ultimate decision on this issue based on the following alternative reasoning.

Subsequent to the ALJ's order, we disavowed the rationale expressed in *Borgelt* and *Berntsen* that a carrier must accept a combined condition before availing itself of the pre-closure denial procedure under ORS 656.262(7)(b). *See Tracy A. Blamires*, 50 Van Natta 1793 (1998), *on recon* 50 Van Natta 2273 (1998). *Linda M. Grover*, 50 Van Natta 2155 (1998); *John K. Harkness*, 50 Van Natta 2055 (1998); *Jerry R. Baugh*, 50 Van Natta 2013 (1998). In so doing, we reasoned that ORS 656.262(7)(b) is applicable when the medical evidence developed subsequent to an acceptance discloses that the compensable injury either combined at the outset, or subsequently combined, with a preexisting condition.

Accordingly, SAIF's denial in the present case was procedurally proper if the medical evidence establishes that claimant's toxic exposure combined with a preexisting condition. The resolution of this 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). The only medical opinion supporting a combined condition is from Dr. Klecan, who examined claimant for SAIF. Dr. Klecan opined that claimant's toxic exposure combined with a preexisting depressive disorder, and that the preexisting disorder was the major contributing cause of claimant's current condition.

The ALJ rejected Dr. Klecan's opinion in concluding that claimant's depressive disorder is a compensable consequence of his toxic exposure. We have adopted and affirmed the ALJ's conclusion and rationale on this issue. It, therefore, follows that Dr. Klecan's opinion is not a persuasive basis for establishing a "combined condition" within the meaning of ORS 656.262(7)(b). Because the record does not otherwise establish a combined condition, SAIF's "pre-closure" current condition denial was procedurally invalid. For this reason, we affirm the ALJ's ultimate decision to set aside the current condition denial.

ALJ's Assessed Attorney Fee Award

SAIF contends that the ALJ erred in awarding claimant an assessed fee for prevailing over its "pre-closure" current condition denial. We adopt and affirm the ALJ's assessed fee award. *Michael C. Leggett*, 50 Van Natta 754 (1998) (to the extent a preclosure denial attempts to deny accepted conditions prior to claim closure, the claimant's counsel is entitled to a fee under ORS 656.386(1) for preserving the claimant's right to compensation related to his accepted condition).[1]

SAIF also requests remand to the ALJ to make findings supporting his attorney fee award under OAR 438-015-0010(4).[2] We are not inclined to consider this argument because SAIF raises it for the first

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[1] In light of this conclusion, we need not address claimant's argument that SAIF is precluded from challenging the ALJ's fee award because its objection was not made at hearing.

[2] *See 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; but findings are necessary to assist the appellate court in carrying out a meaningful review of the competing arguments of the parties); *Daryl L. Underwood*, 50 Van Natta 2330 (1998) (Consistent with *McCarthy* holding, in the absence of specific attorney fee request or specific argument, ALJ may describe or cite the factor(s) of OAR 438-015-0010(4) relied on in determining attorney fee and is not required to make findings of fact on each of the factors); *Russell L. Martin*, 50 Van Natta 313 (1998) (ALJ 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).

time in its reply brief. *See Steven F. Sutphin*, 44 Van Natta 2126 (1992). In any event, because we are authorized under ORS 656.295(6) to supplement or modify the ALJ's findings and conclusions, we reject SAIF's request for remand. *Sherlie A. Dial*, 50 Van Natta 1405 (1998).

Attorney Fee on Review

Claimant is entitled to an assessed fee for services on review. ORS 656.382(2). In determining the amount of this 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."

Here, claimant requests a $2,000 fee for services on review. In support of that request, claimant's counsel reasons that claimant's compensation has been delayed and put at risk, and that most of SAIF's argument on review has already been rejected by the Board and is frivolous. SAIF responds that the requested $2,000 fee is not justified. SAIF reasons that it is impossible to apply the required factors to determine an appropriate attorney fee because claimant's attorney has not submitted a statement of services. SAIF further reasons that the record does not justify a $2,000 fee award because claimant's brief on review relies on a transcription of claimant's closing argument at hearing.

After considering the parties' respective positions and the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services on review is $1,200. In arriving at this amount, we have particularly considered the value of the interest involved, the benefit secured for claimant, the complexity of the issues, and the time devoted to the denial issues (as represented by claimant's respondent's brief). The interest involved and benefit secured are significant, as our decision preserves claimant's right to substantive temporary disability and permanent disability for his accepted toxic exposure condition, and also secures claimant's right to benefits for the denied depressive condition.[3] Finally, we note that claimant is not entitled to a 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 June 17, 1998 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the SAIF Corporation.

[3] We do not regard SAIF's argument on review as frivolous, especially in light of recent Board decisions addressing the validity of preclosure current condition denials under ORS 656.262(7)(b).

In the Matter of the Compensation of
DAVID L. RODAKOWSKI, Claimant
WCB Case No. 98-03325
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that directed it to pay temporary disability (interim compensation) for the period beginning two weeks before February 2, 1998. Claimant cross-requests review of that portion of the order that did not award a penalty for SAIF's allegedly unreasonable failure to pay that compensation. On review, the issues are temporary disability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ directed SAIF to pay interim compensation for the period beginning two weeks before February 2, 1998, reasoning that claimant perfected his aggravation claim on February 2, 1998 (and SAIF's duty to pay interim compensation was therefore triggered), because SAIF received claimant's aggravation claim form and his attending physician's January 6, 1998 chartnote on or before February 2, 1998. We disagree.

ORS 656.273(3) requires that a claim for aggravation "must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative." The statute further provides that the aggravation claim "must be accompanied by the attending physician's attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

Claimant's entitlement to interim compensation depends upon whether SAIF received notice or knowledge of a medically verified inability to work in a medical report that satisfies the requirements of ORS 656.273(3) (and thus constitutes prima facie evidence in the form of objective findings that claimant's compensable condition has worsened). *Susan R. Foster*, 49 Van Natta 2026, 2027 (1997) (citing ORS 656.273(6)); *Russell D. Parker*, 49 Van Natta 83 (1997).

Claimant contends that Dr. Holmboe's January 6, 1998 chartnote constitutes his attending physician's report that he had suffered a worsened condition attributable to the compensable injury.

In the note, Dr. Holmboe related claimant's medical history regarding his right ankle, including the September 21, 1995 work injury, April 1996 surgery, and claimant's ongoing right ankle problems. (Ex. 30-1). Dr. Holmboe provided conservative treatment and opined that further work-up might be necessary to substantiate a diagnosis of "possible posterior impingement of the ankle." (Ex. 30-2). Dr. Holmboe commented that claimant

> "did have a significant injury to the posterior tibiofibular ligament which *could* cause persistent discomfort and pain in this area in my experience. Therefore, the possible diagnosis if [sic] a posterior ankle impingement is *possible given his injury* and response to arthroscopic management." (*Id.*, emphasis added).

Although Dr. Holmboe indicated that claimant's work injury *could* cause persistent right ankle symptoms, he described this as a mere possibility. In our view, the doctor's references to claimant's work injury and current symptoms do not establish that claimant "has suffered a worsened condition *attributable to the compensable injury.*" *See Foster*, 49 Van Natta at 2027. Consequently, we cannot say that claimant perfected his aggravation claim with the January 6, 1998 chartnote or that SAIF's February 2, 1998 receipt of the note triggered a duty to pay interim compensation.[1] Moreover, because we find no

[1] *See also David L. Dylan*, 50 Van Natta 276, 279 n. 3 (Completed aggravation claim *form* by itself not construed as notice to the insurer that the claimant's compensable condition has medically worsened)

evidence that claimant properly filed an aggravation claim more than 14 days before SAIF commenced paying temporary disability benefits (on April 28, 1998), we conclude that claimant is not presently entitled to additional procedural temporary disability under this claim. Finally, there is no penalty issue because there is no compensation due.

ORDER

The ALJ's order dated September 3, 1998 is reversed.

December 17, 1998 Cite as 50 Van Natta 2379 (1998)

In the Matter of the Compensation of
JOSEPH C. VONDRACHEK, Claimant
WCB Case No. 98-02637
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that set aside its denial of claimant's depression and adjustment disorder 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 relied on *David W. Dent, Jr.*, 50 Van Natta 333 (1998), and concluded that, although claimant sought to establish compensability of a psychological condition, the case should nevertheless be analyzed as a consequential condition pursuant to ORS 656.005(7)(a)(A). Accordingly, the ALJ found that the claim was compensable because claimant's accepted low back condition was the major contributing cause of his psychological condition.

Subsequent to the ALJ's order, in *Jackie T. Ganer*, 50 Van Natta 2189 (1998), however, we explained that our reasoning in *Dent* was implicitly disavowed in *Susan M. Ables*, 50 Van Natta 833 (1998). In *Ganer*, we concluded that, because claimant was seeking compensation for a mental condition, the claim must be analyzed under ORS 656.802. *See* 656.802(3); *Fuls v. SAIF*, 321 Or 151 (1995).

Accordingly, in addition to being subject to the "major contributing cause" standard, claimant must prove the existence of his condition with medical evidence supported by objective findings. ORS 656.802(2). Additionally, pursuant to ORS 656.802(3)(a)-(d), the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment.

Several medical opinions have been provided regarding claimant's mental condition. Claimant treated with a social worker, Ms. Kern, who reported that claimant had an adjustment disorder which progressed to a major depressive episode. Ms. Kern believed that claimant's "depression in its various stages was due to his injury." Finally, Ms. Kern reported that the loss of his job was "the straw that broke the camel's back for him." (Ex. 38-2).

Psychologists from the Northwest Occupational Medical Center (NOMC), who advised claimant on pain management, reported that claimant's symptoms did not support a diagnosis of depression. However, the Center's doctors diagnosed an adjustment disorder with depressed mood. The psychologists reported that claimant's condition was "due to his job loss following his injury, concerns about his vocational future and ability to provide for his family, etc." (Ex. 37-B).

Finally, claimant was examined by Dr. Turco, a psychiatrist, on behalf of the employer. Dr. Turco did not agree that claimant had suffered a major depression at any time. He further noted that claimant's stressors included personal problems (family and marital), for which he initiated his counseling with Ms. Kern. Dr. Turco reported that claimant "was very clear with me that his sessions were not related to his workers compensation claim." Dr. Turco also reported that the "administration of his claim was problematic since he felt he would lose his benefits and he also objected to recommendations such as consultation at NOMC." Dr. Turco concluded that, "[m]ost importantly he believes he was unfairly discharge (sic) from employment with the employer and this job dislocation is another factor in his discontent." (Ex. 39).

After reviewing the medical opinions regarding causation, we conclude that Dr. Turco has provided the most persuasive opinion. Dr. Turco took a complete and accurate history and acknowledged that claimant presented "in an honest fashion and his pain is 'genuine.'" (Ex. 36-5). However, Dr. Turco did not attribute claimant's condition to the compensable injury. Rather, Dr. Turco cited noncompensable stressors including family problems and concerns regarding claims processing. (Ex. 39). *See Douglas W. Mansfield, Sr.*, 50 Van Natta 1052 (1998)(the claimant did not show that his *compensable condition* was the major contributing cause of his psychological condition where the contributing factors to the claimant's conditions included his ongoing concerns and fears about the future, his financial status, his wife's health, and his physical limitations from the injury resulting in his being unable to provide for his family). *Also see Baar v. Fairview Training Center*, 139 Or App 196, *rev den* 323 Or 690 (1996)(hypertension not compensable under ORS 656.005(7)(a)(A) because it was caused by the processing of the claim rather than the compensable condition itself).

Consistent with the cases cited above, we further conclude that the opinion of the NOMC psychologists does not support compensability. Specifically, the psychologists reported that claimant's mental condition was attributable to his job loss, concerns about his vocational future and his ability to provide for his family, rather than due to the compensable injury.

Finally, we do not find that the opinion of Ms. Kern is persuasive. According to Dr. Turco's report, claimant first treated with Ms. Kern for personal problems unrelated to the injury. Additionally, Ms. Kern noted that claimant's depression was manifested by focusing on "negative interpersonal relationships and interactions on several levels and by his feelings that the 'system' was often against helping him to the degree he felt he needed." (Ex. 38-1). Nevertheless, Ms. Kern did not discuss claimant's nonwork stressors prior to reaching her conclusion that claimant's depression was due to the industrial injury. *See McGarrah v. SAIF*, 296 Or 145, 166 (1983)(the worker must prove that employment conditions, when compared to nonemployment conditions, were the major contributing cause of the mental disorder).

Similarly, although Ms. Kern indicated that claimant's loss of his job (due to physical limitations caused by the injury) was the "straw that broke the camel's back..."(Ex. 38-2), her opinion in this regard fails to adequately weigh claimant's noncompensable stressors. *See Timothy A. Ragland*, 49 Van Natta 2017 (1997)(although the treating doctor reported that work events precipitated the claimant's current emotional problems, the opinion was not persuasive as it did not adequately weigh the claimant's predisposition). Accordingly, because Ms. Kern's opinion does not provide such an evaluation, we do not find it persuasive.

Under the circumstances, we are unable to say that clear and convincing evidence establishes that claimant's current mental condition arose out of and in the course of employment. ORS 656.802(3)(d). Consequently, we reverse the ALJ's order. The ALJ's attorney fee award is also reversed.

ORDER

The ALJ's order dated July 7, 1998 is reversed in part and affirmed in part. The self-insured employer's March 13, 1998 denial of claimant's adjustment disorder with depressed mood is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GARY PEPPERLING, Claimant
Own Motion No. 98-0481M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable pelvis, urethra and lumbar strain injury. Claimant's aggravation rights expired on October 12, 1989. The employer agrees that claimant's current abnormal urethra, disrupted urethra and prostrate and need for a cystoscopy is causally related to his accepted condition and that it is responsible for claimant's current condition. However, the employer initially contended that it was unknown whether claimant was in the work force at the time of the current disability.

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

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

In response to our November 25, 1998 letter requesting work force information, claimant submitted copies of his 1996, 1997 and 1998 Employee History Report, a copy of his November 21, 1998 unemployment check stub, a copy of a timeslip for the week ending December 6, 1998 (showing claimant having worked on November 30, 1998) and a copy of his November 1998 Work Search Record necessary for unemployment benefits.

We need not address claimant's work force status in 1996 or 1997. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to when his compensable condition worsened requiring surgery and/or inpatient hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, in a November 3, 1998 chart note, claimant's attending physician, Dr. McDuffie, recommended that claimant undergo a cystoscopy. Claimant underwent the recommended surgery on December 2, 1998. Claimant submitted a document from the Employment Department which shows that he received unemployment benefits on November 21, 1998 and actually worked for a couple of hours on November 30, 1998. The receipt of unemployment benefits is *prima facie* evidence that claimant is willing to work and is making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991).[2] Therefore, we find that claimant was in the work force at the time of his current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning December 2, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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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).

[2] The employer responded to claimant's submission and "concede[s] that [claimant] was indeed active in the work force at the time his condition worsened."

In the Matter of the Compensation of
STEPHEN GORDON, Claimant
WCB Case No. 98-02590
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's "back-up" denial of claimant's left wrist injury claim. On review, the issues are the propriety of the "back-up" denial and, if proper, 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

In July 1997, claimant was treated for a left wrist strain resulting from a nonwork-related incident incurred after jumping off of a bridge. In December 1997, claimant again sought treatment for his left wrist after pushing on a board at work the previous month. In January 1998, the insurer accepted a claim for "left navicular fracture." In March 1998, however, the insurer revoked its acceptance and denied the claim.

"Back-up" Denial

ORS 656.262(6)(a) allows a carrier to revoke acceptance and issue a denial when the denial "is for fraud, misrepresentation or other illegal activity by the worker." The carrier also may issue a denial if it accepts a claim in good faith "and later obtains evidence that the claim is not compensable[.]"

The ALJ first found that the insurer failed to prove misrepresentation. But the ALJ further concluded that the insurer "later obtained evidence" that the claim was not compensable. Thus, the ALJ concluded that the revocation of the acceptance and issuance of the denial were procedurally proper.

Claimant first sought treatment at an emergency room, reporting that he "jammed his left wrist" while working; the chartnote indicated that claimant "denies any other trauma." (Ex. 2-1). X-rays in part showed an "old fracture of the navicular bone with non-union." (Ex. 3). After looking at the x-ray, the emergency room physician diagnosed "acute scaphoid fracture." (Ex. 2-2).

When claimant filed his Form 801, he wrote that the "body part affected" was the left wrist and checked "no" as to whether the body part had been previously injured. (Ex. 4).

Claimant then began treating with Dr. Hayes, who reported that claimant "does not recall any prior injuries to his L. wrist pre-dating his injury of about 3 weeks ago or so." (Ex. 5). Dr. Hayes diagnosed a "left navicular fracture, age undetermined." (*Id.*).

After the insurer issued its acceptance, examining orthopedic surgeon, Dr. Hunt, diagnosed a "pre-existing chronic nonunion of the scapho-navicular left wrist, months to years before November, 1997." (Ex. 9-5). According to Dr. Hunt, claimant's fracture preexisted the November 1997 incident based on the "obvious chronic nature[.]" (*Id.*) The day after Dr. Hunt's examination, the insurer revoked acceptance and issued a denial.

The ALJ rejected the insurer's contention that claimant misrepresented his prior history of a left wrist injury by denying on the Form 801 and to the treating physicians any prior injury. After finding that claimant testified in a credible manner, the ALJ accepted claimant's explanation that "in his mind he had not experienced a prior wrist injury because what happened to him in July, 1997 was diagnosed as a sprain and it felt very much different." On review, the insurer renews its contention that there was a misrepresentation.

Although not statutorily required, the Board generally defers to the ALJ's credibility determination when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). But 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).

When testifying, claimant conceded that, in July 1997, he had "hurt" his left wrist. Claimant specifically stated that "if you're referring to sprain as an injury, * * * then yes, I did hurt it." (Tr. 26). Claimant added that he did not consider "me having a sprain was injuring my wrist." (*Id.* at 27).

We find claimant's explanation unpersuasive. In July 1997, five days after jumping off a bridge, claimant sought treatment for a swollen and painful left wrist, had an x-ray taken, was diagnosed with a left wrist sprain, and was placed in a wrist splint. We find such evidence consistent with a layperson's understanding of "injury." In short, we agree with the insurer's assertion that claimant provided misrepresentations to the emergency room physician, Dr. Hayes, and on the Form 801 when he denied previous left wrist injury.

Under ORS 656.262(6)(a), only a material misrepresentation will support a "back-up" denial. *E.g., Ebbtide Enterprises v. Tucker*, 303 Or 459, 464-65 (1987). To demonstrate materiality, a carrier must show that its decision to accept the claim "could reasonably have been affected" if the true facts had been disclosed. *Id.* Claimant contends that any misrepresentation by claimant did not affect the insurer's decision to accept because the insurer knew claimant's left wrist fracture was old, based on the December 1997 x-ray and Dr. Hayes' diagnosis of "age undetermined" fracture.

The December x-ray did find an "old fracture of the navicular bone with non-union." Nevertheless, the emergency room doctor diagnosed an *acute* fracture. Furthermore, Dr. Hayes' reference to "age undetermined" does not conclusively show that claimant specifically injured his wrist in a previous accident.

As stated above, the test is whether the insurer's decision *could* reasonably have been affected. Based on claimant's misrepresentations, the insurer understood that claimant had no previous injury to his left wrist. Although the x-ray and Dr. Hayes' diagnosis counteracted claimant's statements to some extent, we find them insufficient to prove that the insurer knew that claimant had misrepresented his history when it accepted the claim. In this regard, we find the case distinguishable from *Greenbriar Ag Management v. Lemus*, 156 Or App 499 (1998), where the record showed that, at the time of acceptance, the carrier was aware in a general way that the claimant had made prior claims and that the claimant may have misrepresented his medical history to the treating physician.

Furthermore, we find that knowledge of the true facts could reasonably have affected the insurer's decision to accept. According to Dr. Hayes, when he found the July 1997 x-rays, he diagnosed "an established nonunion of his left navicular." (Ex. 11). Dr. Hayes subsequently stated that claimant's navicular fracture "pre-dated his work exposure and very likely pre-dated his July 1997 x-rays." Furthermore, Dr. Hayes thought that, had he known about the prior injury, he could have found claimant's prior medical records and then changed his treatment from simply applying a cast to scheduling surgery "because of what has turned out to be an established nonunion of his left navicular." (Ex. 13).

We find such evidence shows that knowledge of the prior injury would have shown that claimant's left wrist condition preexisted the November 1997 work incident, thus showing that the insurer's decision to accept the left wrist fracture could reasonably have been affected. Consequently, we conclude that the insurer's revocation of acceptance and issuance of the denial are proper.[1]

Compensability

According to both Dr. Hayes and Dr. Hunt, claimant's preexisting left wrist navicular nonunion is unrelated to his employment. (Exs. 9-5, 15). Thus, we agree with the insurer that it proved that this condition is not compensable.

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[1] Based on this decision, we need not address whether the insurer's "back-up" denial was proper under "later obtained evidence."

Claimant asserts that, because Dr. Hayes also stated that claimant's work was the major contributing cause of a left wrist sprain, this condition should be found compensable. We agree.

We first note that, because a left wrist sprain condition was not accepted, it is not subject to ORS 656.262(6)(a). Therefore, the burden is on claimant to prove compensability of the sprain condition. ORS 656.266. Because the medical evidence does not support a conclusion that the work injury combined with claimant's preexisting condition, he must establish that his work was a material contributing cause of his disability and need for medical treatment for his left wrist sprain. *See* ORS 656.005(7)(a)(B); *Beverly Enterprises v. Michl*, 150 Or App 357 (1997); *Gerald A. Glenn*, 50 Van Natta 2087 (1998). In any event, even if the "major contributing cause" standard applied, we are persuaded that claimant has satisfied his requisite burden of proof.

As claimant states, Dr. Hayes found that claimant sustained a sprain (now resolved), which was in major part caused by claimant's employment. Dr. Hunt also found a "possible sprain" if claimant's description of the November 1997 event was accepted. (Ex. 9-5). We consider such evidence sufficient to carry claimant's burden of proof. Although we found above that claimant misrepresented his medical history, we find no basis that he provided unreliable information concerning the November 1997 work event. Thus, we find that Dr. Hayes and Dr. Hunt relied upon a reliable history in forming their opinions concerning the left wrist sprain.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the left wrist sprain. 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 $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 24, 1998 is affirmed in part and reversed in part. The insurer's denial is set aside to the extent it denied claimant's left wrist sprain. The left wrist sprain claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning this issue, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer. The remainder of the order is affirmed.

December 18, 1998 Cite as 50 Van Natta 2384 (1998)

In the Matter of the Compensation of
DEWEY C. HARVEY, Claimant
Own Motion No. 98-0369M
OWN MOTION ORDER
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable contusion of thigh and lumbar muscle strain injury. Claimant's aggravation rights expired on December 16, 1997. SAIF issued a denial of the responsibility for claimant's current herniated disc at L4-5 left with nerve root compression condition on September 4, 1998. Claimant timely appealed that denial. (WCB Case No. 98-06840). In addition, SAIF opposes authorization of temporary disability compensation, contending that claimant's current condition is not causally related to the accepted condition.

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

Here, claimant did appeal the September 4, 1998 denial; however, he withdrew his request for hearing. An Order of Dismissal issued on October 22, 1998. That order has not been appealed. Thus,

the current herniated disc at L4-5 left with nerve root compression condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as SAIF has not accepted responsibility for claimant's current condition. Should claimant's circumstances change and SAIF accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA J. McKINEY, Claimant
WCB Case No. TP-98008
THIRD PARTY DISTRIBUTION ORDER
Stebbins & Coffey, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

AIG Claim Services (AIG) has petitioned the Board for resolution of a dispute regarding a "just and proper" distribution of proceeds of a third-party settlement. *See* ORS 656.593(3). Specifically, the dispute concerns whether AIG waived its third party rights pursuant to a claim disposition agreement (CDA) with claimant and whether AIG can include in its third party lien costs attributable to two insurer-arranged medical examinations (IMEs). We conclude that AIG's third party rights were not waived as a result of the parties' CDA, that the costs of the IMEs are not reimbursable, and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

Claimant was compensably injured on October 17, 1995. AIG accepted a disabling injury claim for head laceration, mild concussion, left upper arm bruising, left cheek contusion, soft tissue bruising, left thigh with paresthetica, left thigh meralgia paresthetica, and left upper leg trochanteric bursitis.

On January 21, 1997, claimant underwent an IME at AIG's request with Drs. Edmonds and Stanford. The physicians were asked to address the diagnosis of the current condition as a result of the compensable injury and to list objective findings. The physicians were also asked to address whether the severity of the injuries or complaints were compatible with the accident, whether or not claimant had any preexisting conditions and, if so, whether or not the preexisting condition combined with claimant's injury. The doctors were also asked whether off work factors caused or contributed to claimant's current symptoms. The remainder of the questions from AIG to Drs. Edmonds and Stanford concerned claim closure issues such as the apportionment of impairment between preexisting conditions and the compensable condition and claimant's medically stationary status.

On March 11, 1997, claimant underwent a second IME with Dr. Baer, an opthalmologist, to address issues related to claimant's vision problem. Dr. Baer was asked to address questions regarding the compensability of the eye condition including whether or not preexisting conditions contributed to the condition and whether the compensable injury was the major contributing cause of the vision problems. In addition to the questions related to compensability, Dr. Baer was asked to address permanent impairment.

Claimant's attending physician concurred with both IME reports, but the record does not reflect that he was asked to perform a closing evaluation prior to the IME exams. In addition, there is no indication that the attending physician was asked to address the "compensability" questions addressed by the IMEs.

The claim was closed following the IME exams with temporary disability only.

After the second IME, AIG partially denied any claimed eye condition or visual impairment and lumbosacral degenerative disc disease. The denial was resolved by a Disputed Claim Settlement that was approved on September 16, 1997.

On September 26, 1997, the Board approved a CDA that fully released claimant's rights to workers' compensation benefits except medical services for the compensable injury. The consideration for the CDA was $6,250. The CDA did not refer to claimant's rights to proceed against a third party or to AIG's rights to seek reimbursement for its claim costs from any third party recovery.

In January 1998, claimant initiated a civil action against the third party. On July 23, 1998, AIG approved a settlement between claimant and the third party for $30,000. AIG asserted a third party lien of $13,856.04, which consisted of indemnity payments of $6,822.97, including $6,250 in CDA proceeds and $7,033.07 in medical expenses. The medical expenses included $425 for a March 11, 1997 IME and $860 for a January 21, 1997 IME, and travel reimbursements of $219.50 and $121.09 for attending the IMEs.

The parties have already distributed the attorney fee and costs associated with the third party settlement as well as claimant's statutory share of the settlement leaving a balance of $13,856.15.

CONCLUSIONS OF LAW AND OPINION

Claimant has requested that we defer deciding the issue of whether, by virtue of the parties' CDA, AIG has waived its right to assert its third party lien. Citing judicial economy, claimant argues that we should defer deciding this issue pending the court's review of our decision in *Benny H. Rash*, 49 Van Natta 2124 (1997). AIG objects to claimant's request. In the absence of an agreement between the parties to hold this matter in abeyance, we decline to do so. *See Carl L. Gruenberg*, 49 Van Natta 750 (1997); *Weston C. Foucher*, 47 Van Natta 1518 (1995).

Pursuant to our decision in *Rash*,[1] and in the absence of an express waiver in the CDA of the carrier's lien rights under ORS 656.580 and 656.593, we conclude that the CDA does not waive AIG's statutory right to assert its third party lien. Accordingly, because AIG has not waived its right to recover its lien, we proceed with our determination of a just and proper distribution.

If the worker settles a third party claim with the paying agency's approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); *Estate of Troy Vance v. Williams*, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

In determining a "just and proper" distribution, we judge each case based on its own merits. *Urness v. Liberty Northwest*, 130 Or App 454 (1994). Since "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. *Id.* Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination was based on the merits of the case. *Id.*

AIG argues that the costs of two IMEs and claimant's travel costs to the IMEs should be included within its third party lien. Specifically, AIG argues that the IMEs were necessitated by Dr. Bert's (claimant's attending physician's) failure to perform a closing examination. AIG further argues that the IMEs were necessary to determine impairment due to claimant's accepted conditions and that the rating of impairment includes distinguishing and apportioning impairment due to the accepted conditions versus impairment due to the noncompensable conditions. On this basis, AIG asserts that questions directed to the IME physicians regarding noncompensable conditions are relevant to the closing examination and that the IMEs should be reimbursable.

It is well-settled that claim evaluation reports are analogous to litigation reports and, as such, are not justly and properly includable in a paying agency's lien against a third party recovery. *Jack S. Vogel*, 47 Van Natta 406 (1995); *David G. Payne*, 43 Van Natta 918 (1991).

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[1] In *Rash*, we interpreted ORS 656.236(1) and concluded that the legislature did not intend for a carrier's third party lien rights to come within the "matters" and "rights to compensation, attorney fees and penalties" resolved by a CDA.

Here, had the record established that the attending physician was reluctant to perform a closing examination, we might have agreed with AIG's argument that the IMEs should be reimbursed. *See Jack S. Vogel*, 47 Van Natta at 409; *see also James A. Cruise, Jr.*, 50 Van Natta 2036 (1998).[2] However, the record does not establish that a closing evaluation was requested from claimant's attending physician prior to the IME. In addition, the IME physicians were asked to address questions regarding compensability of certain claimed conditions. A partial denial was issued subsequent to the IMEs. Given the nature of the questions addressed by the IME physicians in their reports and the subsequent issuance of the partial denial, we are persuaded that the reports were designed for claim evaluation purposes.[3]

Consistent with the cases cited above, we do not consider it "just and proper" for AIG to receive reimbursement for its claim costs attributable to the IME reports. Consequently, AIG will not receive reimbursement for $1,625.59.

In conclusion, we hold that it is "just and proper" for AIG to receive reimbursement for its actual claim costs, *i.e.*, the indemnity costs ($6,822.67, including the CDA expenses) and medical expenses ($5,257.48). *See* ORS 656.593(3). However, for the reasons expressed above, we hold that AIG is not entitled to recover the cost of the two IMEs or the travel costs to the IMEs. Claimant (or his counsel) is directed to forward the aforementioned sum to AIG in reimbursement of its "just and proper" share of claimant's third party settlement. Following that disbursement, the remaining balance of proceeds shall be distributed to claimant. *See* ORS 656.593(3); 656.593(1)(d).

IT IS SO ORDERED.

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[2] AIG argues that the attending physician's willingness to perform a closing examination is not relevant since AIG is authorized to obtain evidence necessary to close the claim based on a preponderance of the evidence. The issue here is not whether AIG has the right to obtain an IME, the issue is whether the IME reports obtained are claim evaluation reports which may not be included in the third party lien. For the reasons given in this order, we find that the reports were claim evaluation reports and that the costs associated with those reports are not includable in the lien.

[3] We acknowledge AIG's argument that it needed to obtain the March 11, 1997 IME because claimant's attending physician was not able to address impairment due to the disputed eye condition. Yet, AIG cites no medical report to support its assertion. In any event, much of the IME report regarding the eye condition appears to relate to compensability, thereby further supporting our conclusion that the report was designed for evaluation purposes.

In the Matter of the Compensation of
JOSEPH C. VONDRACHEK, Claimant
WCB Case No. 98-02637
ORDER OF ABATEMENT
Pozzi, Wilson, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

On December 17, 1998, we issued our Order on Review in this matter. In our order, we reversed the Administrative Law Judge's (ALJ's) order which had set aside the self-insured employer's denial of claimant's adjustment disorder with depressed mood. Citing *Jackie T. Ganer*, 50 Van Natta 2189 (1998), we held that, because claimant was seeking compensation for a mental condition, the claim must be analyzed under ORS 656.802.

Subsequent to our order on review, the Board abated its decision in *Ganer* in order to consider a motion for reconsideration of the "consequential condition"/"ORS 656.802" argument. Accordingly, because we relied on the *Ganer* decision in this case, we are issuing this Order of Abatement on our own motion.

Following our decision on reconsideration in the *Ganer* matter, we will issue an order on reconsideration in the present case.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS W. DAVIS, Claimant
WCB Case No. 96-01528
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's aggravation claim for a cervical condition; (2) awarded an assessed attorney fee of $7,000, subject to an offset; (3) awarded temporary disability; and (4) awarded a penalty for the insurer's allegedly unreasonable denial and failure to pay temporary disability. On review, the issues are the propriety of the aggravation denial under ORS 656.262(7)(c); potentially, aggravation; temporary disability; and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Facts" except we change the first sentence in Fact No. 19 to: "In August 1996, claimant's attending physician, Dr. Weaver, died. (Ex. 60A)."

CONCLUSIONS OF LAW AND OPINION

After a June 1994 work injury, the insurer accepted a claim for disabling C6 fracture and left foot sprain. In December 1994, the insurer closed the claim. The next month, the insurer issued a denial for C5-6 disc herniation. In May 1995, an ALJ set aside the denial and the insurer issued an acceptance for C5-6 disc herniation.

Following the acceptance, the claim remained closed. Meanwhile, in September and December 1995, claimant filed aggravation claims. Claimant again filed aggravation claims in February 1996 and November 1997. In February 1998, the insurer denied the claim for aggravation.

Claim Reopening/Aggravation

We agree with, and adopt, that portion of the ALJ's order concluding that the insurer is required to reopen the claim under ORS 656.262(7)(c).[1] The statute retroactively applies to this claim. *E.g., Ronald D. Smith, Sr.*, 49 Van Natta 1807 (1997).

But we do not adopt the last paragraph on page 4 and instead provide the following supplementation.

As we decided in *Darren D. Hayes*, because we have found that the insurer must reopen the claim under ORS 656.262(7)(c), we need not address the aggravation issue. 49 Van Natta 1956 (1997). That is, whether or not claimant's accepted condition "actually worsened," the reopening of the claim will require the insurer to process the cervical disc herniation condition. In effect, this conclusion "moots" the aggravation issue and, consequently, we need not address the merits of the matter.

Entitlement to Temporary Disability

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

Penalties and Attorney Fees

We adopt and affirm that portion of the ALJ's order discussing penalties except that we do not base a penalty on the aggravation denial because, as discussed above, it is rendered "moot" by ORS 656.262(7)(c). Instead, the penalty is based on the unpaid compensation the insurer unreasonably resisted as of the date of its denial.

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[1] That statute provides that, if "a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

For claimant's attorney's efforts in reopening the claim, the ALJ ordered that "the insurer should initially pay [claimant's attorney] an assessed fee of the difference, if any, of $7,000 and the amount of the assessed fee that the Director awarded in the surgery denial matter."[2] The insurer argues that the ALJ's award in effect ensured that claimant's attorney would be paid a certain sum for his services before the Hearings Division *and* the Director and that the ALJ should have awarded a fee only for services in the proceeding before the ALJ. Claimant agrees that his time spent before the Director should not be considered in the attorney fee award and asserts that the assessed fee should be $6,000.

We determine a reasonable attorney fee by applying the factors set forth in OAR 438-015-0010(4). Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Claimant's counsel asserts that he spent 28 hours on the case at the hearing. The record contains about 70 exhibits, including a deposition lasting one hour and at least two medical reports generated by claimant. The hearing lasted approximately three hours and forty-five minutes; only claimant testified.

The issues in the case were reopening of the claim, aggravation, temporary disability and penalties. Of those issues, claimant is entitled to an assessed attorney fee only for services concerning the reopening and aggravation.[3] Because the reopening issue concerned application of a new statute, the complexity of that matter was higher than average. The value of the interest involved and the benefits secured for claimant were significant, including surgery. Both attorneys were skilled and experienced in the area of workers' compensation law and presented their arguments in a thorough and well-reasoned manner. Based on the divided medical evidence and a vigorous defense, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses were asserted.

We find that, after applying the factors discussed above, $4,500 is a reasonable attorney fee for claimant's counsel's services at hearing. In awarding this fee, we have particularly relied on the complexity of the reopening/aggravation issues, the time devoted to those matters, the value of the interest involved, the benefits secured, and the risk that counsel might go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review concerning the reopening/aggravation and temporary disability 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 $2,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved.

ORDER

The ALJ's order dated April 28, 1998, as reconsidered on June 25, 1998, is affirmed in part and modified in part. That portion of the order awarding an assessed attorney fee of $7,000, offset by the Director's attorney fee award is modified. In lieu of the ALJ's assessed attorney fee award, claimant's attorney is awarded $4,500 for services at hearing to be paid by the insurer. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the insurer.

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[2] According to the parties, there was a proceeding before the Director concerning the insurer's denial of claimant's surgery.

[3] For services regarding temporary disability, claimant's attorney was awarded a portion of that compensation. Counsel is not entitled to an award for services devoted to the penalty issue. *See Saxton v. SAIF*, 80 Or App 631 (1986).

Although claimant's attorney contended that he spent 28 hours for the case at hearing, he did not apportion his time between the different issues litigated at hearing.

In the Matter of the Compensation of
THOMAS G. DOBSON, Claimant
WCB Case No. 97-09982
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) found that claimant's request for reclassification was not time-barred; (2) determined that claimant's claim should be classified as disabling; (3) awarded an out-of compensation attorney fee; and (4) awarded claimant a penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are timeliness of the reclassification request, claim classification, attorney fees and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes.[1] In the second paragraph on page 2, we change the second sentence to read: "On November 25, 1997, the insurer accepted a nondisabling cervical strain/left knee contusion. (Ex. 25)." We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

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

Reclassification

The ALJ found that claimant was off work at least three days before returning to work on either July 22 or 23, 1996. In addition, the ALJ concluded that, because claimant had left knee surgery on February 21, 1997, there was a reasonable expectation that permanent disability would result from the compensable injury.

The insurer argues that the ALJ should have denied claimant's request for reclassification on the merits. The insurer contends that no time loss benefits became due and payable under ORS 656.005(7)(c). The insurer also argues that claimant failed to prove that there was a reasonable expectation that permanent disability would result from the compensable injury.

A "disabling compensable injury" entitles the worker to compensation for disability or death, whereas an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury. ORS 656.005(7)(c). Claimant has the burden of proving that a claim is misclassified. *Normandeau v. Aetna Casualty & Surety Co.*, 120 Or App 184, 189 (1993).

Claimant argues that there was time loss at the time of the injury and time loss after the February 21, 1997 surgery. He asserts that "[y]ou can't have a surgery like that without missing substantial time from work." (Claimant's br. at 3).

Citing ORS 656.277(1), the insurer asserts that the temporary disability benefits referred to in ORS 656.005(7)(c) must become due and payable within the first year after the date of the injury. According to the insurer, any time loss due to claimant's surgery is irrelevant.

We need not address that particular argument because, in any event, the record does not establish how much time claimant missed from work because of his surgery. Dr. Croy performed surgery on February 21, 1997. (Ex. 18). The post-operative reports did not comment on claimant's work status, except to say that at least by April 25, 1997, claimant was back to work full-time. (Exs. 19, 20).

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[1] We modify the ALJ's order to note that Exhibits A, 10A, 15A, 16A and 20A were also admitted in evidence.

Although it seems likely that claimant missed work because of the surgery, the record does not establish how much work, if any, that he missed.

We agree with the insurer that claimant failed to establish that any temporary disability benefits became due and payable under ORS 656.005(7)(c). ORS 656.210(3)[2] establishes a three-day waiting period for entitlement to benefits for temporary total disability. *Bostick v. Ron Rust Drywall*, 138 Or App 552, 555 (1996). A worker is not entitled to begin receiving benefits for temporary disability unless the worker is disabled for more than three calendar days. *Id.* In addition, benefits for disability are not due for the first three calendar days of disability unless the worker is disabled for 14 consecutive days or more. *Id.*

Claimant was compensably injured in a motor vehicle accident on Wednesday, July 17, 1996. On the same date, he sought emergency medical treatment and was discharged. (Ex. 2). He was released to part-time work on Monday, July 22, 1996. (Ex. 6). Claimant's scheduled days off were on Saturday and Sunday. (Ex. 21). The record establishes that claimant missed work on July 18 and 19, 1996, as well as part of the day on July 17, 1996. Although claimant was released to part-time work on Monday, July 22, 1996, the record is not clear as to whether claimant returned to work that day. Claimant thought he had returned to work on "Monday or Tuesday after the accident." (Tr. 19).

Under ORS 656.266, claimant has the burden of proving the nature and extent of any disability resulting from a compensable injury. Based on this record, claimant has not established that he lost time from work as a result of his disability in excess of the three-day waiting period. Moreover, we agree with the insurer the record contains no evidence that claimant's salary was reduced for missing time from work due to the July 17, 1996 accident. Therefore, we are not persuaded that temporary disability benefits were due and payable. *See* ORS 656.210(3); *Julie M. Russo*, 48 Van Natta 436 (1996).

Because no temporary disability benefits are due and payable, claimant's claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Claimant contends there is "no way" that the accepted conditions - including full thickness flap tear of the femoral condyle of the left knee, partial tear of the anterior cruciate ligament, and grade II lesion of the patella of the left knee - would not result in an award of permanent disability. (Claimant's br. at 3).

In construing ORS 656.005(7)(c) and determining whether a compensable injury is disabling, we have required expert medical opinion indicating that a permanent disability award was likely or expected. *See, e.g., Gerasimos Tsirimiagos*, 50 Van Natta 1627 (1998).

Claimant compensably injured his left knee on July 17, 1996. He began treatment with Dr. Croy on August 5, 1996. (Ex. 10). Claimant was treated conservatively until February 21, 1997, when Dr. Croy performed left knee surgery. (Ex. 18). The post-operative diagnoses were left knee full-thickness chondral flap tear of the medial femoral condyle, partial anterior cruciate ligament disruption and medial facet patella grade II lesion. (*Id.*) In the surgical report, Dr. Croy commented that claimant may need a cruciate ligament reconstruction if he has instability and continued knee pain. (Ex. 18-2). He also indicated claimant had a higher risk of having some arthritis in the medial compartment and may eventually need to have an osteoarticular allograft. (*Id.*)

On February 28, 1997, Dr. Croy reported that claimant was doing very well. (Ex 19). He said that he had discussed with claimant the "long-term prognosis of arthritis and instability, given his findings." (*Id.*) On April 25, 1997, Dr. Croy reported that claimant was "improving quite well." (Ex. 20). Claimant had anterior knee pain and described instability, but Dr. Croy felt it was more indicative of quad weakness from his patellofemoral pain. (*Id.*) Dr. Croy found that, overall, the knee was "stable" and he did not find any gross ligamentous instability to correlate with the clinical instabilities. (*Id.*) On September 8, 1997, Dr. Croy signed an "827" form, indicating that it was "undetermined" whether the injury would cause permanent impairment. (Ex. 24). Claimant was released for regular work as of August 1, 1997. (*Id.*)

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[2] ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period."

Although in his earlier reports Dr. Croy indicated claimant might have arthritis and instability in light of the surgical findings (Exs. 18, 19), his April 25, 1997 report indicated that, although claimant had described instability, Dr. Croy felt it was more indicative of "quad weakness." (Ex. 20). On the same date, Dr. Croy reported that claimant's knee was stable and was "improving quite well." (*Id.*) Dr. Croy released claimant for regular work on August 1, 1997. (Ex. 24). In September 1997, he reported that claimant was medically stationary and his permanent impairment was "undetermined." (*Id.*)

Claimant has the burden of proving the nature and extent of disability. ORS 656.266. On this record, we are not persuaded that there is a reasonable expectation that permanent disability will result from the injury. *See* ORS 656.005(7)(c). Despite claimant's assertion that there is "no way" that the accepted surgical conditions would not result in an award of permanent disability, we must have expert medical opinion indicating that a permanent disability award is likely or expected. We acknowledge that the disability standards include awards for knee impairment. *See* OAR 436-035-0230(5). Nevertheless, our findings must be based on medical evidence in the record. *See SAIF v. Calder*, 157 Or App 224 (1998) (Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge; rather, the findings must be based on medical evidence).

In *SAIF v. Schiller*, 151 Or App 58 (1997), *rev den* 326 Or 389 (1998), the court affirmed the Board's disabling classification finding. The court relied on the uncontradicted and credible medical evidence that indicated the claimant's hip strain was reasonably expected to result in permanent disability, as well as the fact that a loss of internal rotation of the hip was a condition recognized by the disability standards.

Here, in contrast, the medical evidence does not support the conclusion that claimant's knee injury is reasonably expected to result in permanent disability. In light of Dr. Croy's notation that claimant's permanent disability is "undetermined," we find that, at best, the evidence is in equipoise whether there is a reasonable expectation of permanent disability. We decline to find that claimant's surgery itself constitutes a reasonable likelihood of *permanent* disability due to the accepted conditions. We therefore reverse the portion of the ALJ's order that reclassified the claim as a disabling injury.

Penalties

The ALJ found that the insurer did not accept the claim until "well beyond" the required 90-day period. The ALJ concluded that the insurer's claims processing was unreasonable and assessed a 25 percent penalty, payable out of any compensation that results from the reclassification of the claim. However, we have concluded that claimant is not entitled to reclassification. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated August 10, 1998 is reversed in part and affirmed in part. The portion of the ALJ's order that directed the insurer to reclassify the claim is reversed. The ALJ's penalty assessment and attorney fee award are also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
DION P. GONZALES, Claimant
WCB Case No. 98-00422
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of his injury claim for an L5-S1 disc protrusion. On review, the issues are evidence and compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the fourth full paragraph on page 3, we change the citation after the second sentence to "(Ex. 91A-4)." We change the first citation on page 6 to "(Ex. 91A)." In the first full paragraph on page 6, we change the first date in the portion of the paragraph quoting from Dr. Woodward's opinion to read "June 16, 1997."

Claimant argues that the ALJ erred in discounting his testimony based on the fact that he had been convicted of a crime involving dishonesty and had been untruthful in the past concerning a workers' compensation matter. Claimant contends that Exhibit 66, a 1995 Opinion and Order, was admissible only to show the disposition of his 1995 claim, but not for character evidence.

The employer contends that claimant did not object to the exhibit at issue, nor did he seek to limit its use to a particular purpose. The employer asserts that claimant did not object to the particular exhibit until closing arguments, after the record had been closed.

We need not address claimant's evidentiary argument because, even if Exhibit 66 was admitted only to show the disposition of his 1995 claim, but not for any other reason, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by not restricting the admission of Exhibit 66 to a particular purpose. *See Jose L. Duran*, 47 Van Natta 449 (1995); *Larry D. Poor*, 46 Van Natta 2451 (1994). After our *de novo* review of the record, even without considering Exhibit 66-4, we find the contemporaneous medical records to be more reliable than claimant's inconsistent testimony. Consequently, where there are inconsistencies, we rely on the contemporaneous medical records. In particular, we agree with the ALJ that the reports from Dr. Sheedy establish that claimant's lumbar strain had resolved by June 24, 1997.

Claimant contends that the ALJ erred by allowing the employer to submit supplemental written arguments after the record had closed.

Following the hearing, the parties submitted written closing arguments. After claimant had submitted his "rebuttal" argument, the employer wrote to the ALJ on July 10, 1998, asserting that claimant had raised several issues and arguments for the first time in the rebuttal. The employer provided its position on the "new" matters raised by claimant. On July 14, 1998, claimant formally objected to the employer's July 10, 1998 submission. In claimant's letter, he responded to the issues raised by the employer's submission.

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. We find no abuse of discretion by the ALJ in allowing the employer's July 10, 1998 submission. In particular, we note that claimant had an an opportunity to respond to the employer's submission.

ORDER

The ALJ's order dated July 28, 1998 is affirmed.

In the Matter of the Compensation of
CHRISTOPHER D. GUFFIE, Claimant
WCB Case No. 98-04910
ORDER OF DISMISSAL
Daniel M. Spencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant requested Board review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration that awarded 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of claimant's left leg (knee). Submitting documents which indicate that claimant applied for and received a lump sum payment of his permanent disability award under ORS 656.230, the insurer seeks dismissal of his appeal. In response, claimant's counsel does not contest the insurer's representation that he requested and received a lump sum payment of his permanent disability award.[1]

ORS 656.230 provides as follows:

> "Where a worker has been awarded compensation for permanent partial disability, and the award has become final by operation of law or waiver of the right to appeal its adequacy, the insurer shall upon the worker's application pay all or any part of the remaining unpaid award to the worker in a lump sum, unless the insurer disagrees with payment, in which case the insurer, within 14 days, will refer the matter to the Director of the Department of Consumer and Business Services to determine whether all or part of the lump sum should be paid."

Here, following the ALJ's order, claimant filed an application with the insurer which sought approval of a lump sum payment of his permanent disability award. The application contained the following provision: "I understand that by applying for and accepting a lump-sum payment of any part of my permanent partial disability award, I waive the right to appeal the adequacy of the award." The insurer approved the application and issued a check in full payment of the remaining balance of claimant's permanent disability award (less a temporary disability overpayment). Thereafter, claimant cashed the check.

Based on the insurer's unrebutted submissions and representations, we are persuaded that claimant has waived his right to appeal the adequacy of his permanent disability award. *See* ORS 656.230(1). Inasmuch as the extent of claimant's permanent disability was the only issue litigated before the ALJ, we conclude that we are not authorized to proceed with our review.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In fact, claimant's counsel acknowledges that, at the time he made the appeal on behalf of claimant, he had forgotten that claimant had already applied for and received a lump sum payment of his award.

In the Matter of the Compensation of
DIANNE R. MURDOCK, Claimant
WCB Case No. 97-02971
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of her injury claim for a low back condition. On review, the issue is compensability.

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

Claimant, age 35 at the time of hearing, began working for the employer in July 1996. In February 1996, claimant saw her family physician, Dr. Sharp, complaining of a sore throat, earache and low back pain. Dr. Sharp diagnosed right otitis media, mechanical low back pain and morbid exogenous obesity. He also prescribed anti-inflammatory medication for claimant's back pain. One month later, claimant called Dr. Sharp's office requesting additional anti-inflammatory medication for her back. He prescribed Naprosen.

On November 18, 1996, while off the employer's premises and on her afternoon break, claimant tripped on a curb in a public parking lot across the street from the employer's office. She fell forward, landing on her hands and knees. She skinned her left knee and felt pain, but picked herself up and returned to work for the day.

Claimant awoke the next day with low back pain, but went to work. She found sitting uncomfortable, however, and left work at noon. Her symptoms continued, and she did not work the next day.

Claimant sought treatment on December 9, 1996 and was prescribed muscle relaxants.[1] Six days later, on December 15, 1996, she sought emergency treatment complaining of low back pain. Claimant advised Dr. Singer that she had experienced intermittent back pain for years, which had worsened over the past two or three weeks since she fell on all fours while walking on a wet surface.

Following her emergency room visit, claimant continued to treat with Dr. Sharp, who diagnosed acute lumbosacral strain on top of mechanical low back pain and morbid exogenous obesity. A December 31, 1996 MRI of the lumbar spine showed, among other things, disc desiccation and degenerative disc disease at L4-5 with a possible disc herniation. Thereafter, Dr. Sharp referred claimant to Dr. Freeman, a neurosurgeon.

Claimant saw Dr. Freeman on January 7, 1997, who diagnosed L5 radiculopathy right side as a consequence of a disc herniation with nerve root compromise. A January 8, 1997 myelogram also demonstrated a disc herniation at L4-5, greater on the right side with nerve root compromise.

On January 18, 1997, Dr. Freeman performed surgery. His post-surgical diagnosis was fibrocartilage with degenerative changes at L4-5.

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[1] On review, claimant argues that there is insufficient evidence in the record to support a finding that claimant sought treatment on december 9, 1996. we disagree. although the record does not include a december 9, 1996 chart note, there are references to, and mentions of, such a visit in other exhibits in the record. indeed, the nurse's notes accompanying claimant's december 15, 1996 emergency room visit state that claimant "saw pmd and started on muscle relaxers *6 days ago*." (Ex. 3A, emphasis added.) Similarly, Dr. Sharp's December 20, 1996 chart note (Ex. 5) suggests that claimant had visited his office recently, as he noted that claimant came in "complaining of continued back pain from last visit." Dr. Sharp explained that "now [claimant] states that this was a result of an on-job injury" when she slipped an fell in late November 1996. (Ex. 5). Along the same line, after reviewing claimant's medical records (including those of claimant's visits to Dr. Sharp's office dating back to February 1996), Dr. White reported that claimant saw Dr. Sharp on December 9, 1996 and advised him that she had "thrown her back out" the prior week. (Ex. 29-1). We find this evidence sufficient to establish the fact that claimant sought treatment for back pain on December 9, 1996.

In March 1997, the employer denied claimant's low back injury, asserting that the injury did not occur in the course and scope of her employment and, alternatively, that the November 18, 1996 incident was not the major contributing cause of her L4-5 disc herniation.

On May 12, 1997, Dr. Freeman reported that, per claimant's related history, the major cause of her herniated nucleus pulpusos was her fall at work on November 18, 1996.

Dr. White performed a review of claimant's medical records at the insurer's request. He concluded that the major cause of claimant's L4-5 disc condition was degenerative spondylosis at the L4-5 level, aggravated by her morbid obesity. Dr. White also opined that claimant's fall was not a major or material cause of her low back condition.

Looking first to the medical causation question, the ALJ determined that Dr. Freeman's opinion was based on an incomplete history and was conclusory and, therefore, he found the opinion unpersuasive. Because the ALJ found that claimant failed to prove by a preponderance of the evidence that her November 18, 1996 fall was the major contributing cause of her combined low back condition or need for treatment, the ALJ did not address whether claimant's fall occurred within the course and scope of employment.

On review, claimant contends that Dr. Freeman's opinion is persuasive evidence that her November 18, 1996 fall was the major contributing cause of her disc herniation. Claimant further contends that the ALJ erred in not addressing the course and scope issue, and seeks remand or resolution of this issue on review.

We agree with the ALJ that claimant has not sustained her burden on medical causation. Because the causation issue is determinative, we need not address claimant's alternative arguments concerning the course and scope issue.

Claimant does not dispute that her low back condition results from a combination of factors and therefore compensability must be analyzed under the major contributing cause standard set forth in ORS 656.005(7)(a)(B). Rather, claimant asserts that Dr. Freeman was aware of claimant's prior history of low back complaints and her preexisting conditions and took these factors into account in identifying the November 18, 1996 incident as the major cause. We find to the contrary.

In satisfying the "major contributing cause" standard, claimant must show that the compensable injury contributed more to his low back condition or need for treatment than all other factors combined. *See McGarrah v. SAIF*, 296 Or 145, 146 (1983). The persuasive medical opinion must evaluate the relative contribution of different causes and explain why work exposure or injury contributes more to the claimed condition than all other causes or exposures combined. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995).

In this case, although Dr. Freeman identified claimant's fall as the major contributing cause of her disc herniation at L4-5, he provided no further analysis or explanation for this opinion. He related claimant's condition to the fall "per [claimant's] related Hx [history]" without addressing the relative contribution of her preexisting degenerative changes or her obesity, two conditions which Dr. White identified as contributing to claimant's low back condition and need for treatment. Therefore, his opinion does not satisfy the "major contributing cause" standard. Moreover, because Dr. Freeman understood that claimant had no low back symptoms prior to her November 18, 1996 fall,[2] his opinion is not based on a complete and accurate 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 her burden of proof.

ORDER

The ALJ's order dated August 25, 1998 is affirmed.

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[2] Dr. Freeman understood that claimant slipped on a side walk and subsequently experienced neck and low back discomfort, as well as buttock and right leg pain, extending down to the foot. He also noted: "The patient states that previous to the above mentioned onset she can recall no similar symptoms" and that "just prior to the above mentioned onset she was completely free of symptoms." (Ex. 12).

In the Matter of the Compensation of
DIANA D. NGUYEN, Claimant
WCB Case No. 97-10081
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Stoel Rives, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that upheld its denial of claimant's occupational disease claim for a right knee condition. On review, the issue is compensability.

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

In concluding that claimant proved compensability, the ALJ found that claimant's treating orthopedic surgeon, Dr. Pelmas, provided the most persuasive opinion. The employer disputes the ALJ's assessment of the medical evidence, alleging that examining orthopedic surgeon, Dr. Gambee, and claimant's former treating occupational health specialist, Dr. Thiessen, provided the more reliable medical opinions concerning causation. In particular, the employer argues that Dr. Pelmas did not consider other potential causes of claimant's condition and she did not rely on an accurate history because she did not consider claimant's previous right knee symptoms or claimant's earlier statements to medical providers concerning her duties at home. According to the employer, because Dr. Thiessen based his opinion on such considerations, we should defer to that opinion.

We disagree with the employer's characterization of Dr. Thiessen's opinion. Dr. Thiessen indicated that "the etiology of [claimant's] right knee condition is unknown." (Ex. 34A-2). However, contrary to the employer's assertions, Dr. Thiessen did not base this opinion on claimant's previous right knee treatment[1] or any potential contribution from off-work activities. Instead, Dr. Thiessen agreed that claimant's work duties were not the type to cause claimant's right knee condition. (*Id.*)

In the absence of medical evidence that claimant's previous treatment and/or statements are relevant to claimant's current right knee condition, the history relied upon Dr. Pelmas is not inaccurate or incomplete. Furthermore, for the reasons discussed by the ALJ, we agree that Dr. Pelmas provided the more reliable medial opinion and, thus, claimant proved compensability.

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

ORDER

The ALJ's order dated August 5, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the self-insured employer.

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[1] In fact, Dr. Thiessen agreed that his previous treatment of claimant was "for a separate problem[.]"

In the Matter of the Compensation of
RHONDA M. SPARKS, Claimant
WCB Case Nos. 98-04517 & 98-02823
ORDER ON REVIEW
John C. DeWenter, Claimant Attorney

Reviewed by the Board *en banc.*

Liberty Northwest Insurance Corporation, on behalf of Westwood Swinerton Construction, requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its responsibility denial of claimant's injury claim for an elbow fracture; and (2) upheld Johnston and Culberson, Inc.'s[1] denial of the same condition. On review, the issue is subjectivity.

We adopt and affirm the ALJ's order with the following changes and supplementation.[2]

In the third sentence of the fourth paragraph on page 2, we replace the words "In fine" with "In practice." On page 3, we delete the second full paragraph.

We supplement the ALJ's order to address Liberty's argument that *Larry G. Falls*, 47 Van Natta 234 (1995), controls the outcome of this case.

Claimant was employed as a bookkeeper by Denali Drywall (Denali). On February 3, 1997, Denali entered into a subcontract with Westwood Swinerton Construction (Westwood), a general contractor, for completion of a construction project. (Ex. Aa1-1). The subcontract required Denali to provide appropriate insurance certificates before commencing work. (*Id.*) Denali provided Westwood with two insurance certificates for workers' compensation insurance, one with the SAIF Corporation, effective from April 1, 1996 to March 31, 1997, and one with Affordable Insurance Concepts, Inc., which showed coverage effective March 31, 1997 to March 31, 1998. (Exs. AA, 1D).

The work on the construction project began on April 22, 1997. (Tr. 23). On July 16, 1997, claimant was injured while in the course and scope of her employment with Denali. On September 9, 1997, claimant's attorney filed a claim with Denali. (Ex. 2). The Department of Consumer and Business Services (DCBS) issued an order finding that Duane Gerlach (dba Denali Drywall) was a noncomplying employer during the period of April 1, 1997 to March 8, 1998. (Exs. 9, 11A). SAIF, as the processing agent for Denali, issued a denial of responsibility on February 12, 1998. (Ex. 10). SAIF asserted that Westwood was responsible for claimant's injury. (*Id.*)

Claimant filed a claim with Westwood. (Ex. 11). Liberty, on behalf of Westwood, denied the claim on May 7, 1998. (Ex. 14). Claimant requested a hearing on both denials.

The ALJ found that claimant's activities at the time of her injury were a normal and customary part of the employer's trade or business. *See Bret Claussing*, 50 Van Natta 640 (1998). The ALJ concluded that Liberty, on behalf of Westwood (the general contractor), was responsible for claimant's injury because the subcontractor (Denali) did not have insurance coverage when it began work on the project.

On review, Liberty does not dispute the ALJ's conclusion that claimant's activities at the time of her injury were a normal and customary part of the employer's trade or business. Rather, Liberty argues that *Larry G. Falls*, 47 Van Natta at 234, is controlling. Liberty contends that, because Denali certified to Westwood that it had workers' compensation insurance before work began on the project, Johnston and Culberson, Inc. (Johnston), as the claims processor for Denali, is responsible for the claim.

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[1] Although the SAIF Corporation issued the February 12, 1998 denial (Ex. 10), the Department of Consumer and Business Services subsequently transferred responsibility for processing this claim to Johnston and Culberson, Inc.

[2] We modify the ALJ's order to reflect that Exhibits Aa-1, 1A and 1E were also admitted to evidence. We base this modification on the parties' responses to the Board's staff counsel's inquiry into the admissibility of the exhibits.

In *Larry G. Falls*, 47 Van Natta at 235, we found that the subcontractor had Washington workers' compensation coverage before labor under the contract commenced. At that time, the subcontractor had no Oregon subject employees. The claimant, an Oregon subject worker, was hired by the subcontractor after work under the contract had commenced. We concluded that, because the subcontractor had adequate workers' compensation coverage at the time labor under the contract began, the subcontractor assumed responsibility for providing coverage for all its employees while working on the contract, including employees hired after labor under the contract began. We also found that the subcontractor was charged with the responsibility of providing coverage for the claimant, since it had certified to the general contractor that it had adequate coverage before labor under the contract began. We concluded that the claimant's remedy was with SAIF, in its capacity as claims processor for the subcontractor.

To the extent our holding in *Falls* was based on the subcontractor's "certification," we find that conclusion to be inconsistent with the express language in ORS 656.029(1).[3] In *Falls*, we relied, in part, on the fact that the subcontractor had *certified* to the general contractor that it had adequate insurance coverage. ORS 656.029(1), however, assigns responsibility for coverage for a subcontractor's nonexempt worker to the prime contractor unless the subcontractor "*provides* such coverage for those individuals before labor under the contract commences." *Liberty Northwest Ins. Corp. v. Hegerberg*, 118 Or App 282, 286 (1993) (emphasis added). The statute requires that the subcontractor must actually *provide* insurance coverage before the contract commences, not merely *certify* that such coverage exists. The administrative rule is consistent with ORS 656.029(1) by requiring that insurance must be *provided*. *See* OAR 436-050-0040(1)(a).[4]

Here, Denali provided Westwood with two insurance certificates for workers' compensation insurance, one with the SAIF Corporation, effective April 1, 1996 to March 31, 1997, and one with Affordable Insurance Concepts, Inc., which showed coverage effective March 31, 1997 to March 31, 1998. (Exs. AA, 1D). Despite the fact that Denali had certified that it had insurance coverage, it did not actually *provide* workers' compensation insurance before labor under the contract commenced on April 22, 1997. Based on the express statutory language of ORS 656.029(1), the subcontractor must provide such coverage for those individuals before labor under the contract commences. Because Denali did not provide workers' compensation insurance, we conclude that Westwood, as the general contractor, is responsible for claimant's work injury. To the extent our holding is inconsistent with our decision in *Larry G. Falls*, we disavow our holding in *Falls*.

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[3] ORS 656.029(1) provides:

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

[4] OAR 436-050-0040(1)(a) provides:

"When a person awards a contract, that person is responsible for providing workers' compensation coverage on all individuals performing labor under the contract if the labor under the contract is a normal and customary part or process of that person's trade or business unless:

"(A) The individuals performing labor under the contract are exempt as nonsubject workers under ORS 656.027;

"(B) The person to whom the contract was awarded is registered pursuant to ORS 701.075 and is performing work described by ORS Chapter 701; or

"(C) At the time work commences, the person to whom the contract was awarded *provides workers' compensation insurance* for those individuals performing labor under the contract." (Emphasis added).

ORDER

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

December 22, 1998 Cite as 50 Van Natta 2400 (1998)

In the Matter of the Compensation of
LARRY D. GILBERT, Claimant
WCB Case No. 98-03040
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of his low back aggravation claim. On review, the issue is aggravation.

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

The ALJ upheld the insurer's denial of claimant's aggravation claim, finding that, even though claimant's low back condition had "actually worsened," the medical evidence did not establish that claimant's compensable 1992 low back injury was the major contributing cause of his current low back condition. On review, claimant contends that the ALJ should have applied a "material contributing cause" standard and found that his current low back condition is compensably related to the 1992 injury.

We need not decide which legal standard (material or major contributing cause) applies. That is, even if claimant is correct that the less stringent material causation standard applies, we agree with the ALJ's reasoning that the physicians on whom claimant relies are not persuasive. Therefore, even if we applied the material contributing cause test, we would still find the aggravation claim not compensable.

ORDER

The ALJ's order dated September 5, 1998 is affirmed.

In the Matter of the Compensation of
YUNG THOMPSON, Claimant
WCB Case No. 98-02801
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of claimant's occupational disease claim for right upper extremity/neck conditions. On review, the issue is compensability.

We adopt and affirm the ALJ's order, except for the last sentence, with the following supplementation.

Dr. Jura provides the only medical evidence supporting the claim. He opined that claimant has a predisposition, or unusual sensitivity,[1] which makes her very susceptible to overuse injury. (*See* Ex. 35-22-25, -28-29). Dr. Jura opined that claimant's work activities, specifically, 7-10 keyboard mouse "clicks" per hour, 10 hours per day, were the major contributing cause of her upper extremity problems. But Dr. Jura never explained why he believes that claimant's limited mouse "clicks" contributed more to her condition than all other causes combined--particularly the unusual predisposition that he believes her to have. Under these circumstances, we find Dr. Jura's opinion unpersuasive and we decline to rely on it. Consequently, we agree with the ALJ that claimant has not established that her work activities were the major contributing cause of her conditions.

ORDER

The ALJ's order dated July 30, 1998 is affirmed.

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[1] Dr. Jura estimated that claimant was probably in "a top five percentile of people who have problems with this [type of activity]." (Ex. 35-29).

In the Matter of the Compensation of
BRUCE SHRIVER, Claimant
WCB Case No. 98-03483
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its partial denial of claimant's claim for his spondylolisthesis, spondylolysis at L5-S1, and combined low back conditions; and (2) awarded claimant's attorney an assessed fee of $3,000 for services at hearing. In his brief on review, claimant requests that we increase the assessed fee awarded by the ALJ. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following exception, supplementation, and summary. We do not adopt the ALJ's findings of ultimate fact.

On November 20, 1996, claimant sustained a compensable injury when he was struck in the stomach with a 16 foot laminated beam and slammed back about three feet onto a stack of lumber. On December 3, 1996, SAIF accepted the claim for a low back contusion and anterior thigh contusion. That same date, Dr. McAndrew, claimant's treating physician, found claimant's low back condition medically stationary without evidence of permanent impairment.

Claimant did not seek any treatment from November 26, 1996 through October 24, 1997, although he continued to experience intermittent stiffness, soreness and popping in his low back that gradually worsened. On October 24, 1997, claimant returned to Dr. McAndrew with complaints of chronic low back pain. Dr. McAndrew referred claimant to Dr. Bert, orthopedist, who first examined claimant on November 12, 1997, and diagnosed grade I spondylolisthesis and spondylolysis at L5-S1. (Exs. 10, 17, 28). Dr. Bert stated that the November 20, 1996 work injury caused claimant's low back symptoms and need for treatment. (Ex. 28).

On January 14, 1998, Dr. Schilperoort, M.D., examined claimant on behalf of SAIF. Following claimant's normal bone scan, Dr. Schilperoort explained that claimant's spondylolysis and spondylolisthesis conditions preexisted the November 20, 1996 work injury and were not caused by any trauma within the previous five years. (Ex. 30). He opined that claimant's preexisting spondylolysis and spondylolisthesis conditions are the major cause of his combined condition. (Exs. 26, 30). Although Dr. Schilperoort described the mechanism by which an injury such as claimant's causes a previously asymptomatic unstable back to become symptomatic, he also concluded that, when compared to claimant's preexisting condition, the work injury was not the major contributing cause of claimant's symptoms and need for treatment. (Ex. 30-4-5).

CONCLUSIONS OF LAW AND OPINION

Based on the medical evidence, the ALJ found that claimant's work injury combined with his preexisting low back condition to cause disability or need for treatment. Thus, the ALJ found ORS 656.005(7)(a)(B)[1] applicable to claimant's claim. We adopt the ALJ's reasoning and conclusions that

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

"(7)(a) A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

* * * * * *

"(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

claimant's current low back condition is a "combined condition" within the meaning of ORS 656.005(7)(a)(B). However, we disagree with the ALJ's conclusion that claimant met his burden of proof under that statute.

Under ORS 656.005(7)(a)(B), claimant must prove that his work activities were the major contributing cause of his disability or need for medical treatment for his combined condition. *SAIF v. Nehl*, 148 Or App 101, *recon* 149 Or App 309 (1997). Determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1997), *rev dismissed* 320 Or 416 (1995). Furthermore, given the combination of the preexisting spondylolisthesis and spondylolysis conditions and the work injury, 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); *Barnett v. SAIF*, 122 Or App 279, 282 (1993) (when a case involves a medically complex condition, there must be expert medical evidence establishing causation).

Only Dr. Bert, claimant's current attending physician, and Dr. Schilperoort, examining physician, provide opinions regarding the cause of claimant's disability and need for treatment. Their opinions differ as to this causation issue.

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Claimant argues that we should give greater weight to the opinion of Dr. Bert because he is the treating physician. Absent persuasive reasons to the contrary, generally we defer to the opinion of the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). We find persuasive reasons in this case not to defer to Dr. Bert's opinion.

Although stating that the major contributing cause of claimant's combined condition and his disability and need for treatment was the November 1996 work injury, Dr. Bert did not explain his opinion. (Ex. 28). He also did not address claimant's normal bone scan, which Dr. Schilperoort persuasively explained established that claimant's spondylolysis and spondylolisthesis conditions were preexisting. Finally, Dr. Bert did not evaluate the relative contribution of the different causes of claimant's need for treatment of the combined condition. In this regard, although acknowledging that spondylolysis results in an unstable spine and the most likely scenario was that the work injury combined with a preexisting spondylolysis condition to cause or aggravate the instability, Dr. Bert did not evaluate the contribution of claimant's preexisting spondylolysis condition to his disability and need for treatment. (Ex. 28). Given all of these problems with Dr. Bert's opinion, we do not find it persuasive.

The ALJ found, and claimant argues, that notwithstanding Dr. Bert's opinion, Dr. Schilperoort's opinion establishes that his work activities were the major contributing cause of his disability or need for medical treatment for his combined condition. We disagree.

Following claimant's normal bone scan, Dr. Schilperoort explained that claimant's spondylolysis and spondylolisthesis conditions preexisted the November 20, 1996 work injury and were not caused by any trauma within the previous five years. (Ex. 30). He opined that claimant's preexisting spondylolysis and spondylolisthesis conditions are the major cause of his combined condition. (Exs. 26, 30). We note that claimant is *not* required to prove that the work injury is the major contributing cause of the entire combined condition in order to establish a compensable combined condition. Instead, claimant must prove only that the work injury is the major contributing cause of his disability or need for medical treatment for his combined condition. ORS 656.005(7)(a)(B); *Nehl*, 149 Or App at 315 (court rejected carrier's argument that a claimant must prove the work injury was the major contributing cause of the entire combined condition and concluded that, "regardless of the extent of [a] claimant's underlying condition, if [the] claimant's work injury, when weighed against [the] preexisting condition, was the major cause of [the] claimant's need for treatment, the combined condition is compensable"). Nevertheless, for the following reasons, we do not find that Dr. Schilperoort's opinion meets this burden of proof.

Although Dr. Schilperoort described the mechanism by which an injury such as claimant's causes a previously asymptomatic unstable back to become symptomatic, he also concluded that, when compared to claimant's preexisting condition, the work injury was not the major contributing cause of claimant's symptoms and need for treatment. (Ex. 30-4-5). Thus, Dr. Schilperoort's opinion does not support compensability of claimant's combined condition. Accordingly, we uphold SAIF's denial.

ORDER

The ALJ's order dated August 27, 1998 is reversed. The SAIF Corporation's partial denial of claimant's claim for his spondylolisthesis, spondylolysis at L5-S1, and combined low back conditions is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
BRIAN S. MacDONALD, Claimant
Own Motion No. 98-0378M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable back strain, thoracic injury. Claimant's aggravation rights on that claim expired on July 21, 1991. SAIF opposed reopening on the grounds that: (1) no surgery or hospitalization was requested; (2) the current condition is not causally related to the accepted condition; (3) SAIF was not responsible for claimant's current condition; (4) surgery or hospitalization was not reasonable and necessary for the compensable injury; and (5) claimant was not in the work force at the time of disability. SAIF did not formally deny the compensability of and/or responsibility for claimant's current condition as part of his 1986 claim. However, alleging unreasonable delay in accepting or denying a claim for claimant's low back condition as part of his 1986 claim, claimant requested a hearing with the Hearings Division. (WCB Case No. 98-04071).

We consolidated this own motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time his condition worsened.

By Opinion and Order dated November 20, 1998, ALJ Howell found that claimant had suffered a new injury in February 1998 and thus a non-own motion insurer was responsible for claimant's current low back condition. That order was not appealed.[1]

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

Here, responsibility for claimant's current low back condition falls with a subsequent non-own motion insurer and is not compensably related to claimant's 1986 claim. As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*

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

IT IS SO ORDERED.

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[1] Per our Own Motion Order consolidating the own motion matter with the pending litigation, ALJ Howell issued his own motion recommendation concurrent with his November 20, 1998 Opinion and Order. ALJ Howell recommended we not exercise our authority under ORS 656.278 since he found a subsequent non-own motion insurer responsible for claimant's current low back condition.

In the Matter of the Compensation of
GARY L. DAY, Claimant
WCB Case No. 97-02137
ORDER ON REVIEW
Blake & Schilling, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that dismissed his request for hearing as untimely. In his brief, claimant objects to the admission of Exhibit 13A and raises the issues of temporary disability and penalties for an allegedly unreasonable denial and alleged failure to timely pay temporary disability compensation. On review, the issues are dismissal, compensability, temporary disability, penalties, and evidence. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On October 22, 1995, claimant experienced an on-the-job injury to his left knee. Later the same day, he went hunting and hyper-extended the same knee when he slipped on wet gravel. When claimant returned to work on October 25, 1995, he reported the left knee injury incident to the employer, but did not report that his medical services were work-related. (Ex. 8C).

On October 26, 1995, claimant sought treatment from Dr. Tesar. He reported to Tesar that he injured his knee at work and that it swelled up two to three hours later. Tesar diagnosed a contusion, left tibial tubercle, and a partial tear of the patellar tendon and took him off work. (Exs. 2, 5, 5A).

On October 27, 1995, claimant filed a claim for short-term disability for a non-work related knee injury. (Ex. 2A). On November 6, 1995, Tesar released claimant to modified work. (*Id.*). Claimant was paid his regular wage while he performed modified work. On November 25, 1996, an MRI revealed tears of the medial and lateral menisci and anterior cruciate ligament from an old injury and a contusion over the anterior aspect of the tibia and partial tearing of the patellar tendon. (Ex. 5A).

In March 1996, claimant became represented by an attorney, Mr. Blake. On April 2, 1996, claimant filed an "801" for the October 1995 left knee injury. (Ex. 8).

On May 23, 1996, the insurer's claims investigator interviewed claimant, who told her he was represented by Blake. The insurer reported that it did not have a copy of the retainer agreement. (Ex. 8E). The insurer received a copy of the retainer agreement on July 9, 1996. (Tr. 57).

On August 2, 1996, Mr. Blake acknowledged receipt of the partial taped conversation with claimant and requested that the insurer accept the claim. (Ex. 8F).

On November 14, 1996, the insurer arranged an appointment with Dr. Laycoe, orthopedic surgeon. The insurer sent the appointment notice by certified mail to claimant's designated address. On November 16, 1996, claimant's mother signed the receipt for certified mail. Dr. Laycoe examined claimant on December 4, 1996. (Exs. 8G, 9, 10).

On December 27, 1996, the insurer accepted claimant's injury claim for a nondisabling "contusion to front of left knee involving intrapatellar and tibial metaphyseal bone." (Ex. 11). Both claimant and his attorney received copies of the acceptance.

On December 31, 1996, the insurer mailed by certified mail to claimant's designated address a partial denial of medial and lateral tears to the cartilage, degenerative joint disease, and an anterior cruciate deficiency of the left knee. On January 3, 1997, claimant's mother signed the certified mail receipt. (Ex. 12).

On January 23, 1997, Scott Eave, the employer's Director of Human Resources, spoke with claimant regarding his left knee claims. (Ex. 13A, Tr. 45, 46).

On February 10, 1997, Mr. Blake wrote to the insurer requesting that the insurer clarify its position regarding the other conditions for which claimant was treated. (Ex. 13C). On the same date, Blake telephoned the insurer regarding the acceptance and some labor issues of concern to claimant. (Ex. 13B; Tr. 26, 59). The insurer advised Blake that "partial denial, he was cc." (Ex. 13B). Although he did not inform the insurer during their conversation whether he had received the denial, Blake advised the insurer that he would appeal the denial. (Ex. 13B; Tr. 60). The insurer did not provide a written response to Blake's February 10, 1997 letter, nor did it fax him a copy of the denial. (Tr. 60, 64).

On March 7, 1997, Mr. Blake again telephoned the insurer regarding the February 10, 1997 letter and the status of the denial. (Tr. 28, 65). The insurer advised Blake that it had issued a partial denial on December 27, 1996. (Ex. 14A). Blake advised the insurer that neither he nor claimant had received a copy of the denial. The insurer stated that it would fax him a copy of the denial, which it did on March 10, 1997. (Ex. 14). On March 10, 1997, claimant filed a request for hearing. On September 18 and October 14, 1997, claimant filed supplemental hearing requests raising the additional issues of procedural entitlement to temporary disability, classification of the claim, date of knowledge of the claim, penalties and attorney fees.

At hearing, claimant objected to the receipt of Exhibit 13A into evidence. (Tr. 9 through 12).

CONCLUSIONS OF LAW AND OPINION

After convening a hearing on January 16, 1998, the ALJ concluded that claimant had not established "good cause" for failing to file his request for hearing on the partial denial within 60 days of the date the denial was mailed and issued an order dismissing the request for hearing. The ALJ subsequently granted claimant's request for reconsideration on the issues of interim compensation, temporary disability, and related penalties. After considering the parties' additional arguments regarding these issues, the ALJ issued an order on reconsideration in which he dismissed the request for hearing. On review, claimant raises the issues of dismissal, temporary disability, interim compensation, and penalties.

Dismissal

The insurer accepted claimant's initial claim on December 27, 1996 and mailed its partial denial on December 31, 1996. On March 10, 1997, claimant filed his request for hearing on the denial. On September 18, 1997, claimant filed an amended request for hearing, raising additional issues of a challenge to the notice of acceptance, procedural entitlement to temporary disability, classification of acceptance, revision of date of knowledge, and penalties.

Subject to ORS 656.319 (which sets time limits within which a claimant must request a hearing on a denial of a claim), any party * * * may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute * * *. ORS 656.283(1). A hearing request on a claim denial must be filed no later than the 60th day after a carrier mails a denial, or, if a hearing request is filed after 60 days, but within 180 days of a denial, a hearing shall not be granted unless the claimant proves "good cause" for failure to file the request by the 60th day after mailing. ORS 656.319(1)(a), (b). Because claimant's request for hearing on the partial denial was filed after March 3, 1997, claimant must establish that he had "good cause" for his late filing.[1] ORS 656.319(1)(b).

Claimant contends that, because neither he nor his attorney had actual notice of the denial until 7 days after the 60-day period tolled, and because they were reasonably diligent to become aware of the denial, he has established good cause for his late filing. We disagree.

A claimant's failure to receive a properly mailed notice can form the basis for a claim of good cause for failure to request a hearing within 60 days of the notice under appropriate circumstances. *SAIF v. Curtis*, 107 Or App 625 (1991), citing *Giusti v. Adams*, 102 Or App 329, 333 (1990). Moreover, the carrier's failure to serve the denial on a claimant's attorney may be such "good cause." *See, e.g., Freres Lumber Co. v. Jegglie*, 106 Or App 27 (1991); *Cowart v. SAIF*, 94 Or App 288 (1988). Mistake, inadvertence, surprise or excusable neglect, as those terms are used in ORCP 71B(1), constitute good cause. *E.g., Hempel v. SAIF*, 100 Or App 68, 70 (1990). Claimant has the burden of proving good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1984).

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[1] There is no dispute that claimant filed his claim more than 60 days but within 180 days of December 31, 1996, the date the insurer mailed the partial denial.

Here, the insurer sent the partial denial notice by certified mail to claimant at the address provided by him, which was the home of his mother. Claimant's mother signed for the letter on January 3, 1997. Although claimant concedes that he had constructive notice of the denial as of that date, he testified that he did not actually receive the insurer's denial because his mother "stuck it away somewhere." (Tr. 45). Claimant also testified that the employer's Director of Human Resources, Mr. Eave, showed him a piece of paper that Eave said was a denial during a meeting on January 23, 1997, but claimant was not permitted to hold or read the document. (Tr. 48). Finally, claimant testified that he did not actually see the denial until his then-attorney, Mr. Blake, showed him a copy some time after March 10, 1997. (Tr. 42). The ALJ gave no indication that claimant's testimony regarding notification of the denial was not credible. We therefore conclude that claimant did not actually receive the denial letter until after March 10, 1997.

Claimant's testimony, however, also establishes that he was aware of the existence of the denial on January 23, 1997, well within the 60-day period. Claimant contacted Mr. Blake sometime prior to February 10, 1997, regarding problems he was having at work, but there is no evidence that claimant advised Blake that a denial had issued. (Tr. 26, 27).

On February 10, 1997, within the 60-day period, Mr. Blake wrote to the insurer explaining that he had received the December 27, 1996 Notice of Claim Acceptance and requesting that the insurer clarify its position regarding the status of the unaccepted conditions. During a telephone conversation the same day, the insurer informed Blake that a partial denial of the unaccepted condition issued and that he was copied. (Ex. 14). Blake did not tell the insurer whether or not he had received a copy of the denial and did not request one.

On March 7, 1997, four days after the 60-day period had run, Mr. Blake again telephoned the insurer to ask about the status of the denial, stating that neither he nor claimant had received a copy. When notified of the denial, Mr. Blake requested a copy by fax, which the insurer provided on the following Monday, March 10, 1998. Mr. Blake filed a request for hearing the same day.

On this record, we agree with the ALJ that claimant has failed to establish good cause for filing his hearing request more than 60 days after the insurer mailed the denial. Claimant had actual knowledge, even if not actual receipt, of the denial on January 23, 1997. Claimant offered no reason for failing to inform his attorney of the fact that he knew a denial had issued. Moreover, there is no reasonable explanation in the record why claimant's attorney did not clearly establish the date the denial issued or specifically request a copy of the denial or file a hearing request regarding the denial before the expiration of the 60-day period. Neglect by an attorney who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. *See Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977); *EBI Companies v. Lorence*, 72 Or App 75, 78 (1985). Therefore, under these circumstances, we conclude that claimant failed to act with due diligence to protect his legal rights. As a result, claimant has not established "good cause" for his late filing and the ALJ properly dismissed claimant's request for hearing on the insurer's partial denial.[2] However, our inquiry does not end here.

The ALJ concluded that claimant was not entitled to interim compensation, and stated that he was without authority to make any rulings with respect to claimant's "substantive" entitlement to compensation. Then the ALJ dismissed claimant's request for hearing in its entirety. On review, claimant also raises the issues of his entitlement to interim compensation and temporary disability in relation to the accepted portion of the claim, and related penalties for allegedly improper claims processing. In effect, claimant is contending that the ALJ's dismissal of these issues was improper. We agree.

Claimant's specification of issues in his September 18, 1997 amended request for hearing can reasonably be interpreted as having raised these issues at hearing. *See Liberty Northwest Ins. Corp. v. Alonzo*, 105 Or App 458 (1991). Moreover, the ALJ addressed the issues of interim compensation and temporary disability at reconsideration. Thus, because a request for hearing regarding a matter concerning a claim can be raised at any time, and because there is no other procedure for resolving the temporary disability, interim compensation and penalty disputes under the circumstances of this claim, we have jurisdiction to address these issues. ORS 656.283(1). Accordingly, we reinstate claimant's hearing request insofar as it relates to these issues.

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[2] Because we have found without regard to Exhibit 13A that claimant failed to act with due diligence to timely file his claim, we need not address whether its admission was an abuse of discretion by the ALJ.

Temporary Disability

Here, claimant has been not been declared medically stationary and his claim is still open. Therefore, the issue raised by claimant is procedural (not substantive) temporary disability. *See* ORS 656.268; *Kenneth P. Bundy*, 48 Van Natta 2501 (1996).

Temporary Disability/Interim Compensation

As a preliminary matter, we note that the insurer argues that, because claimant failed to request reclassification of his claim to disabling status, we should find that claimant is not entitled to time loss. To the extent that the insurer's argument may be read to contend that we do not have jurisdiction over the issue of entitlement to procedural temporary disability (including interim compensation) on a claim accepted as nondisabling, we disagree with that contention. *See Steven V. Bischof*, 44 Van Natta 225, *on recon* 44 Van Natta 433 (1992), *aff'd mem Freightliner Corporation v. Bischof*, 115 Or App 758 (1992) (the actual issue presented was the claimant's procedural entitlement to temporary disability benefits; by deciding the claimant's procedural entitlement to temporary disability, the Board does not reach the disabling/nondisabling status issue, which is within the Director's jurisdiction, nor the substantive entitlement issue, which is determined at claim closure); *Joseph E. Bridwell*, 49 Van Natta 1061 (1997); (the Board has jurisdiction to address claimant's entitlement to interim compensation benefits in a claim that had been accepted as nondisabling). Accordingly, based on *Bischof* and *Bridwell*, we conclude that we have jurisdiction to address claimant's "procedural" entitlement to temporary disability benefits, including interim compensation.

Procedural temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status. *See SAIF v. Taylor*, 126 Or App 658 (1994). Because claimant's claim remained open, the issue in this case concerns entitlement to procedural temporary disability. During an open claim, a claimant is entitled to procedural temporary disability for those periods of time for which an attending physician has authorized temporary disability. ORS 656.262(4) (a) and (f).

Here, claimant experienced two injuries on the same day, one at work and one off work. Therefore, claimant must prove both that his attending physician, Dr. Tesar, authorized temporary disability, and that the authorization for such disability was due to the compensable injury. We find that claimant has failed to establish both elements, reasoning as follows.

There is no dispute that Dr. Tesar, who diagnosed claimant's condition as contusion, left tibial tubercle, took claimant off work and authorized temporary total disability beginning October 26, 1995, and temporary partial disability beginning November 6, 1995, the date claimant was able to return to modified work. (Exs. 2, 2A). On November 25, 1995, an MRI revealed an anterior cruciate ligament (ACL) tear and meniscal tears. However, the record indicates that Dr. Tesar was not informed until November 30, 1995, that claimant experienced a second, off-the-job injury to his left knee on October 22, 1995.

Dr. Laycoe, who examined claimant and performed a chart review for the insurer on December 4, 1996, opined that claimant's initial treatment by Dr. Tesar through the initial evaluation in January 1996 by Dr. Michael Vessely was solely related to the contusion, and not to the later-diagnosed conditions. (Ex. 10-8). Dr. Jon Vessely, however, opined that claimant's ACL tear also occurred on October 22, 1995, and was the major cause for claimant's continued need for treatment; however, he was unable to attribute the ACL tear to either the work injury or the off-work injury. (Ex. 17).

On this record, we conclude that, although claimant was taken off work, he has not established that he lost time from work due to his compensable condition, particularly in light of Dr. Tesar's lack of knowledge regarding the second injury to claimant's left knee until after he took claimant off work. *Somers v. SAIF*, 77 Or App 259 (1986) (we give the most weight to opinions that are both well-reasoned and based on complete information). Therefore, claimant has not established that he is entitled to procedural temporary disability benefits due to his compensable injury.

As for entitlement to interim compensation, the ALJ found that the insurer did not have notice or knowledge of the claim until April 2, 1996, at which time claimant was working at his regular job at his regular wage and there was no current authorization of time loss. Claimant contends that the employer had knowledge that claimant injured his knee at work on October 25, 1995, and, therefore, he is entitled to interim compensation and/or temporary disability beginning as of that date. We conclude that claimant is not entitled to interim compensation.

Temporary disability compensation is required to 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. ORS 656.262(4)(a). "Interim compensation" refers to temporary disability payments which ORS 656.262 requires to be made to a claimant who is off work as a result of an injury for the time between the employer's notice of the injury and acceptance or denial of the claim. *Jones v. Emanuel Hospital*, 280 Or 147 (1977).

Here, although the employer was aware that a left knee incident occurred at work, claimant filed a claim for short term, non-work related disability. Dr. Tesar signed the form and indicated that claimant's knee contusion did not arise out of claimant's employment. (Exs. 2, 2A). Consequently, we find that the insurer did not have notice of the claim for a work-related condition until claimant filed an "801" on April 2, 1996.

In any event, the insurer did not have medical verification of claimant's inability to work due to the injury prior to its December 27, 1997 acceptance of the claim. Accordingly, no interim compensation is due.

Penalties and Attorney Fees

Claimant requested penalties for an unreasonable denial and for unpaid time loss to date. Because claimant's request for hearing on the partial denial was untimely, the denial stands. Likewise, because claimant has not established entitlement to time loss, there are no amounts "then due" upon which to assess a penalty for the employer's allegedly unreasonable denial or unpaid time loss. ORS 656.262(11); *Anderson v. E.B.I. Companies*, 79 Or App 345 (1986) (no assessment of penalty where the claimant had failed to prove compensability of an aggravation claim that had been "de facto" denied).

ORDER

The ALJ's order dated May 14, 1998 is reversed in part and affirmed in part. Insofar as the order dismissed claimant's request for hearing on the issues of temporary disability and penalties, the order is reversed and claimant's request for hearing on those issues is reinstated. Claimant's requests for temporary disability, interim compensation, and penalties are denied. Insofar as the order dismissed the request for hearing on the denial issue, it is affirmed.

December 28, 1998 Cite as 50 Van Natta 2409 (1998)

In the Matter of the Compensation of
RANDAL C. CHATMAN, Claimant
WCB Case No. 97-09880
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
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) Nichols' order that awarded an assessed attorney fee of $2,800 for services at hearing. SAIF also moves to remand. In his respondent's brief, claimant requests sanctions. On review, the issues are remand, attorney fees, and sanctions. We deny the motions for remand and sanctions and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant's counsel an assessed attorney fee of $2,800 for services at hearing in prevailing against SAIF's denial of a low back condition; claimant's attorney did not submit a statement of services and there was no argument by the parties concerning attorney fees. Citing to *Schoch v.*

Leupold & Stevens, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), SAIF contends that a decision-making body "must make specific findings of fact under each of the factors [contained in OAR 438-015-0010(4)] that will allow a reviewer to determine if an abuse of discretion occurred." According to SAIF, because the ALJ did not provide such reasoning, the order is "inadequate to justify any award of an attorney fee" and moves for remand "with instructions to take evidence and properly apply OAR 438-015-0010(4)."

We considered the same argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). There, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Court's entire decision in *McCarthy*, we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, pursuant to our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

But, like the ALJ in *Underwood*, the ALJ in this case simply ordered SAIF to pay the assessed attorney fee "pursuant to ORS 656.386(1) and OAR 438-015-0010(4)." Because the ALJ did not describe or cite the specific factor or factors within the rule, we agree with SAIF that the ALJ's reasoning in arriving at the fee amount is not sufficient for review. Nevertheless, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary 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 and proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing. *Daryl L. Underwood*, 50 Van Natta at 2332.

Although claimant's attorney did not do so at hearing, on review, counsel submits statements of services alleging that a total of 33.15 hours were devoted to the case.[1] As noted above, the issue at hearing was compensability of claimant's low back injury claim. The hearing lasted three hours; five witnesses testified. The record was made up of 23 exhibits; at least two medical reports were generated by claimant's attorney.

As compared to compensability disputes generally presented to this forum for resolution, the issue in this case was of average complexity.

The value of the interest involved and the benefit secured for claimant also were more than average because claimant required surgery for a herniated disc. Because the medical reports concerning the herniated disc were divided, there was a risk claimant's attorney would go uncompensated. Finally, both attorneys were experienced and skillful.

Based on these factors, especially the complexity of the issue, the value of the interest involved and the risk that claimant's counsel would go uncompensated, we agree with the ALJ that $2,800 is a reasonable attorney fee.

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[1] A statement of services was submitted by each of claimant's attorneys; the statements did not clarify what portion of time was spent at hearing, as opposed to review, and what portion was devoted to the compensability issue, as opposed to the attorney fee issue. Thus, we find the statements to be little help in deciding a reasonable fee for services devoted to the compensability issue at hearing.

Furthermore, the statements of services indicate a figure of over $10,000 as the total "amount of fee sought." However, because claimant's respondent's brief asks that we "affirm" the ALJ's order without explicitly requesting a greater fee, we do not consider claimant as asking us to increase the attorney fee awarded at hearing. Moreover, assuming any such request by claimant, based on the reasoning in this order, we affirm the ALJ's attorney fee award.

In his respondent's brief, claimant asks for sanctions, alleging that SAIF's request for review is frivolous. We deny the request. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2). Based on the Court's opinions in *Schoch* and *McCarthy* and the limited reasoning in the ALJ's order explaining the attorney fee award, SAIF presented a colorable argument that was sufficiently developed so as to create a reasonable prospect of prevailing on the merits.

Finally, claimant is not entitled an attorney fee for his counsel's services on review regarding the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 17, 1998 is affirmed.

December 28, 1998 Cite as 50 Van Natta 2411 (1998)

In the Matter of the Compensation of
JAMES F. EMOND, Claimant
Own Motion No. 98-0445M
OWN MOTION ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The insurer initially submitted claimant's request for temporary disability compensation for his left knee injury. Claimant's aggravation rights expired on June 18, 1991. By a November 3, 1998 Own Motion Order, we authorized the reopening of claimant's 1975 claim for the payment of temporary disability compensation.[1]

The insurer subsequently requested reconsideration, contending that claimant has withdrawn from the work force and is not entitled to temporary disability compensation. We abated our November 3, 1998 order to allow claimant time to respond to the insurer's contentions.

In response to our abatement order, claimant states that "[he] has, for all times relevant to these proceedings, withdrawn from the work force." Based on claimant's response, we conclude that he agrees with the insurer's assertion that he has withdrawn from the work force. Consequently, we find that claimant is not entitled to the reopening of his claim for the payment of temporary disability compensation. *See Violet Allquist*, 50 Van Natta 209 (1998); *John B. Shaw, Sr.*, 50 Van Natta 10 (1998).[2]

Accordingly, on reconsideration, in lieu of our November 3, 1998 order, the request for own motion relief for the payment of temporary disability is denied. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] The insurer submitted its own motion recommendation on a prior version of the Board's Own Motion Recommendation form. Based on this out-dated form, we erroneously interpreted the insurer's recommendation as a request that the claim be reopened for the provision of temporary disability compensation.

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

In the Matter of the Compensation of
JEROME O. JOHNSON, Claimant
WCB Case No. 98-03420
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that assessed a $3,500 attorney fee for services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

The ALJ considered several issues at hearing. First, he decided that claimant did not provide untimely notice of his claim to the employer. The ALJ then determined that claimant proved compensability of a herniated disc but not a prostate condition. With regard to an attorney fee, the ALJ wrote that, "[i]n light of the criteria set out in OAR 438-015-0010(4) * * * especially the time claimant's attorney * * * devoted to this matter and the benefit to claimant by prevailing against the denial of a fairly significant condition, $3,500 is a reasonable assessed fee."

On review, SAIF contends that *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), and *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), required the ALJ to: (1) make findings for each factor in OAR 438-015-0010(4); (2) draw conclusions from those findings of fact; and (3) demonstrate how the conclusions are weighed in determining a reasonable attorney fee. Because the ALJ did not provide such reasoning, SAIF argues that we should remand the case "with instructions to take evidence and properly apply OAR 438-015-0010(4)."[1]

We considered the same argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). There, the claimant's attorney did not submit a specific fee request and the parties did not provide any argument at hearing concerning the application of the factors in OAR 438-015-0010(4). After analyzing the Court's entire decision in *McCarthy*, we found that the Court held that a lower body need not address facts and legal criteria that are not material to its decision and could "satisfy its obligation to make findings in a case * * * by including in its order a brief description or citation to the factor or factors on which it relies in denying an award of attorney fees." 327 Or at 188.

In short, because the statute considered by the Court in *McCarthy* contained the same requirement in OAR 438-015-0010(4) that the reviewing bodies "shall consider" certain enumerated factors, we held that it is sufficient for an ALJ to merely describe or cite the rule-based factor or factors the ALJ relied on in determining a reasonable attorney fee where there was no specific attorney fee requested and the parties did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, we rejected the carrier's argument in *Underwood* that the ALJ was required to make findings for each rule-based factor.

The only difference between *Underwood* and this case is that claimant's attorney submitted a statement of services to the ALJ. That submission, however, was not challenged or disputed by SAIF at hearing (or on review); similarly, SAIF did not (and continues not to) provide any discussion or argument concerning the application of the rule-based factors. Thus, in light of the Court's discussion in *McCarthy*, we find the ALJ's order adequate for review.

Furthermore, having found the ALJ's order sufficient and because we may modify or supplement it on review, we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. Consequently, we deny SAIF's motion for remand. *Daryl L. Underwood*, 50 Van Natta at 2330.

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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.

Finally, in addition to the ALJ's discussion, we provide the following reasoning. We first note that claimant's attorney's statement of services indicated that counsel devoted 20 hours, and estimated an additional 2 hours, to the case. Because claimant did not prove compensability of the prostate condition, however, we do not consider time devoted to this issue. With regard to the time factor, we further note that the hearing lasted 2 hours and 45 minutes and three witnesses testified. The record was made up of 28 exhibits, including a 20 minute deposition, and at least one medical report generated by claimant's attorney.

We find the issues to be more complex than average because the ALJ had to decide whether or not claimant timely notified the employer of the claim, which required the ALJ to assess testimony that was in direct contradiction.

The value of the interest involved and the benefit secured for claimant also were more than average because claimant may require surgery. (Exs. 18, 19). Because the medical reports concerning the herniated disc were divided, there was a risk claimant's attorney would go uncompensated. Finally, both attorneys were experienced and skillful.

Based on these factors, especially the complexity of the issues and the value of the interest involved, we agree with the ALJ that $3,500 is a reasonable attorney fee.

In his respondent's brief, claimant asks for sanctions, alleging that SAIF's request for review is frivolous. We deny the request. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2). Based on the Court's opinions in *Schoch* and *McCarthy* and the limited reasoning in the ALJ's order explaining the attorney fee award, SAIF presented a colorable argument that was sufficiently developed so as to create a reasonable prospect of prevailing on the merits.

Finally, because attorney fees are not "compensation" for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for his counsel's services on Board review regarding the defense of the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 28, 1998 is affirmed.

December 28, 1998 Cite as 50 Van Natta 2413 (1998)

In the Matter of the Compensation of
RICHARD A. LAWRENCE, SR., Claimant
WCB Case No. 97-06318
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of his complex medial meniscus tear of the right knee. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, age 49 at the time of hearing, has worked for the employer since 1992. In 1995, he began working in the door division, operating a "Kval" machine to drill door knob holes and hinge pockets in doors. This job entailed twisting, turning and pivoting to place the doors in the machine, and operating a series of floor pedals.

Beginning in January 1997, claimant noted discomfort and swelling in his right knee while at work. He continued working, although his symptoms worsened over the next several weeks. On February 24, 1997, claimant sought treatment with Dr. Christensen, who suspected degenerative arthritis. His x-rays were normal.

Claimant's right knee symptoms continued. On March 18, 1997, he began treating with Dr. Gargaro, who sent claimant for an MRI, which showed a complex tear of the posterior horn of the medial meniscus and degenerative changes.

In late April 1997, Dr. Gargaro performed a partial arthroscopic medial meniscectomy. During surgery, Dr. Gargaro also found grade I to II chondromalacia in the medial compartment, synovitis and a hypertrophic medial parapatellar shelf impinging upon the medial femoral condyle.

Dr. Hanesworth took over claimant's care in July 1997. By this time claimant had returned to work, although he continued to experience intermittent pain and swelling in his right knee.

The employer denied the compensability of claimant's right knee condition, asserting that his work activities did not cause his disability or need for treatment. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to establish by a preponderance of the evidence that his disability or need for treatment was caused in major part by his incident of pain in January 1997 or his overall work activities for the employer. On review, claimant argues that, under ORS 656.005(7)(a)(B)[1] and *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997),[2] he has shown that his work activity was the major contributing cause of his need for treatment for his combined knee condition. We find to the contrary.

As a preliminary matter, we must decide whether claimant's meniscal tear should be analyzed as an injury or an occupational disease.[3] The courts treat a condition as an occupational disease when the symptoms are gradual in onset, not attributable to a specific event, and due to an ongoing condition or state of the body. *James v. SAIF*, 290 Or 343 (1981); *Valtinson v. SAIF*, 56 Or App 184 (1982); *O'Neal v. Sisters of Providence*, 22 Or App 9, 16 (1975). These same cases treat a condition as an injury when the symptoms occur over a discrete, identifiable period of time and are due to a specific activity or event. *Id. See also Mathel v. Josephine County*, 319 Or 235, 240 (1994) (an "injury" is an event and a "disease" is an ongoing condition or state of the body or mind).

Here, for the reasons that follow, we conclude that claimant's meniscal tear is properly analyzed as an occupational disease under ORS 656.802. When claimant first sought treatment for his right knee on February 24, 1997, Dr. Christensen noted that claimant had been experiencing discomfort and swelling over the last several weeks, with "no known injury." (Ex. 1A-1). Similarly, when claimant saw Dr. Gargaro on March 18, 1997, he did not relate his knee condition to any specific injury. Dr. Gargano noted that claimant did a lot of pivoting on his right leg at work, but that claimant "can't remember an abrupt change in activity or a discrete injury that initiated [his symptoms]." (Ex. 2-1).

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[1] This section provides:

"If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

[2] In *Nehl*, the court clarified the standard of proof required under ORS 656.005(7)(a)(B) regarding combined condition claims. The court explained that a claimant need not establish that the compensable injury is the major contributing cause of the entire combined condition; instead, the claimant need only establish that the compensable injury is the major contributing cause of the need for treatment of the combined condition to establish compensability of the combined condition. 149 Or App at 312, 314-15.

[3] If claimant's claim is properly analyzed as an occupational disease, then we need not address claimant's argument based on *SAIF v. Nehl*. Unlike ORS 656.005(7)(a)(B), ORS 656.802(2) does not distinguish between the major contributing cause of the need for treatment of the combined condition and the combined condition itself. Instead, ORS 656.802(2) refers solely to the combined condition itself.

Furthermore, in completing an 827 Form (First Medical Report) on April 1, 1997, claimant attributed his condition to "repeated pivoting on his right leg" at work, rather than to any one particular injurious incident.[4] (Ex 5).

Although claimant testified at hearing that, on or about January 8, 1997, he felt a "pop" in his right leg and noted swelling of the knee after pivoting at work, we find this testimony inconsistent with the contemporaneous medical records that deny any particular traumatic event. Rather, based on the contemporaneous medical records and claimant's written indications (on the 801 and 827 forms) that his symptoms were related to repeated activity rather than a discrete event, we find that claimant's claim is properly analyzed as an occupational disease.

Under ORS 656.802(2), claimant must establish that his employment conditions were the major contributing cause of his meniscal tear. Moreover, because the record establishes that claimant's work exposure combined with a preexisting degenerative condition in the right knee, claimant must prove that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Three physicians have offered opinions concerning the cause of claimant's condition. All three doctors agreed that claimant had a complex, degenerative-type meniscal tear (involving tearing in multiple directions and planes), rather than a simple, single line tear. (Exs. 16-4, 20-6, 21-7). In his deposition, Dr. Gargano explained that, given claimant's preexisting, underlying degenerative condition, claimant was predisposed to a meniscal tear. He opined that claimant's work activity, which entailed pivoting with the knee in a flexed and loaded position, likely accelerated the need for a meniscectomy, but the degenerative condition, which was not related to claimant's work activity, made the surgical procedure inevitable. (Ex. 20). Dr. Hanesworth opined that, in the absence of any specific injurious event, he could not relate claimant's meniscal tear to his work activity within a reasonable medical probability. (Ex. 21). Finally, Dr. Tesar, who reviewed claimant's medical records at the employer's request, opined that although claimant's work activity produced symptoms in his knee, it did not cause the degenerative complex tear nor did it pathologically worsen the condition. (Ex. 16-3). Dr. Tesar based his opinion on the fact that claimant denied any specific injury or significant event at work, and claimant's report that the symptoms stopped when he was not pivoting on his knee. (Ex. 16-3).

After considering these medical opinions, we are not persuaded that claimant's employment conditions were the major contributing cause of his combined condition and pathological worsening of the disease. At best, Dr. Gargano's opinion indicates that claimant's work exposure precipitated his meniscal tear and accelerated his need for surgery, but the record does not establish that claimant's work activity was the major cause of his combined condition. *See Dietz v. Ramuda*, 130 Or App 397 (1994) (determining the major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause). Because none of the medical experts identified claimant's work activity as the major cause of claimant's meniscal tear, nor the major cause of a pathological worsening of the disease, we uphold the employer's denial.

ORDER

The ALJ's order dated July 9, 1998 is affirmed.

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[4] On the 801 Form, which claimant completed on April 4, 1997, he listed January 8, 1997 as the date of injury, but did not describe any specific incident. Instead, he reported that his "knee swells and pops because of pivoting, while working my machine. Repetitive movement." (Ex. 7).

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Case Nos. 94-10782, 94-10774, 94-10781, 94-10773 & 94-05124
SECOND 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

Claimant has requested reconsideration of our September 23, 1998 Order on Remand that set aside Douglas County Forest Products/Liberty Northwest Insurance Corporation's (DCFP/Liberty's) denial of his occupational disease claim for bilateral hearing loss. Claimant requests reconsideration, contending that he is entitled to a penalty for unreasonable resistance to compensation, as well as an assessed attorney fee at the hearings level and on Board review.

On October 12, 1998, we abated our prior order to allow for additional time to allow the carriers to respond to claimant's motion. After considering the supplemental brief from Murphy Plywood/Liberty Northwest (Murphy/Liberty), we now proceed with our reconsideration.

Penalties - Murphy Plywood/Liberty Northwest

Claimant contends that he is entitled to a penalty for "unreasonable resistance," particularly by Murphy/Liberty. He previously argued on review that he was entitled to a penalty against Murphy/Liberty (among others) for an unreasonable delay because it failed to timely process the claim. On reconsideration, claimant refers to a December 8, 1994 hearing in which all the parties were present except Murphy/Liberty. After the hearing, Murphy/Liberty moved to reopen the hearing. According to claimant, the only issue in the supplemental hearing was whether Murphy/Liberty had received notice of the claim and notice of hearing. The ALJ denied the motion to reopen the hearing. Claimant contends that Murphy/Liberty's attempt to claim nonreceipt and lack of notice of a hearing was "unfounded" and resulted in unnecessary additional administrative proceedings and a delay in the ultimate payment of compensation.

On reconsideration, Murphy/Liberty asserts that, because the court found in its favor on the issue of responsibility, claimant has no grounds for a penalty or penalty-related attorney fee.[1] We disagree.

In *SAIF v. Whitney*, 130 Or App 429 (1994), the court upheld the assessment of penalties against two insurers, although only one was responsible for the claim. The court concluded that the language of *former* ORS 656.262(10)(a) did not indicate that the legislature intended to limit the total amount of penalties that could be awarded. 130 Or App at 432. Rather, the statute limited only the total amount of penalties that could be awarded against any one carrier. The court reasoned: "[i]f two insurers, or for that matter, four insurers, act unreasonably, we see no reason why they should not each be liable for a penalty of up to 25 percent." *Id.*

Former ORS 656.262(10)(a) has since been amended and renumbered to ORS 656.262(11)(a). Nevertheless, the language the court relied on in *Whitney* remains in the current version of the statute. ORS 656.262(11)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

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[1] We acknowledge that the court's opinion was confined to the issues of compensability and responsibility regarding claimant's occupational disease claim. Nonetheless, because the court reversed our prior order and remanded for reconsideration, we are authorized to consider all issues that were raised during our initial review. *Bret Claussing*, 50 Van Natta 640, n. 4 (1998); *Kevin P. Silveira*, 47 Van Natta 2354, 2357 n. 3 (1995), *on recon* 48 Van Natta 298 (1996). Here, because we initially affirmed the ALJ's determination that the claim was not compensable, we likewise concurred that there were no amounts then due on which to assess a penalty for allegedly unreasonable claim processing. Inasmuch as we have now found the claim to be compensable and the responsibility of a particular carrier, it is necessary to consider the merits of claimant's previously raised penalty issue.

Based on *SAIF v. Whitney*, although Murphy/Liberty has not been found responsible for claimant's claim, we must still address whether it is liable for a penalty for unreasonable delay in processing the claim.

We summarize the relevant facts. On March 7, 1994, claimant's attorney sent a letter to Murphy/Liberty, providing notice of an occupational disease claim for hearing loss. (Exs. 20, 102). At the December 8, 1994 hearing, claimant contested Murphy/Liberty's "de facto" denial of his claim. Murphy/Liberty failed to appear at the hearing. Murphy/Liberty's attorney wrote to the ALJ on December 16, 1994, stating that he had just received the file. The ALJ treated the letter as a motion to reopen the record, which was denied on January 10, 1995. On January 24, 1995, Murphy/Liberty filed a second motion to reopen the record on the basis that no claim had been made against Murphy/Liberty. Murphy/Liberty submitted an affidavit from the plant superintendent, stating that Murphy/Liberty's business records did not contain a copy of claimant's March 7, 1994 claim letter against it.

The ALJ held a hearing on Murphy/Liberty's motion to reopen the record on February 22, 1995. On March 16, 1995, the ALJ issued an order denying Murphy/Liberty's motion to reopen the record. The ALJ found that claimant's attorney had mailed a claim for hearing loss to Murphy/Liberty on March 7, 1994, and he determined that Murphy/Liberty had received that exhibit in the normal course of business. The ALJ also found that Liberty had adequate notice of the claim against Murphy/Liberty. The ALJ concluded that Liberty failed to properly process claimant's claim against Murphy/Liberty.

After reviewing the record and the transcript of the February 22, 1995 hearing concerning Murphy/Liberty's motion to reopen the record, we agree with the ALJ's conclusion that Murphy/Liberty received claimant's counsel's March 7, 1994 letter in the normal course of business, that Liberty had adequate notice of a claim against Murphy/Liberty, and we also agree with the conclusion that Liberty failed to properly process claimant's claim against Murphy/Liberty. We find that Murphy/Liberty did not accept or deny the claim within 90 days as required by ORS 656.262(6)(a).

Under these circumstances, we conclude that Murphy/Liberty unreasonably delayed processing the claim. We conclude that a penalty for unreasonable conduct may be assessed against Murphy/Liberty, although no amounts are due under the claim against it. *See SAIF v. Whitney*, 130 Or App at 432. Accordingly, because Murphy/Liberty's failure to accept or deny the claim was unreasonable, we conclude that a penalty of 25 percent of amounts due claimant (from DCFP/Liberty) is appropriate. This penalty (which shall be equally shared by claimant and his counsel) shall be paid by Murphy/Liberty and will be based on the compensation payable by DCFP/Liberty on March 16, 1995 (the date the record closed) as a result of this order.

Penalty - Huffman and Wright Logging

Claimant argued on review that he was entitled to a penalty against Huffman and Wright Logging (Huffman) for the unreasonable delay in claim processing because it failed to timely process the claim. We do not address this argument because the Court of Appeals noted in the appellate judgment that Huffman and its insurer Liberty Northwest Insurance Corporation were dismissed from this case by order dated August 8, 1997.

Penalty - Parkway Ford

On review, claimant argued that he was entitled to a penalty against Parkway Ford (Parkway) for the unreasonable delay in claim processing because it failed to timely process the claim.

On May 23, 1994, claimant's attorney sent a letter to Parkway, providing notice of an occupational disease claim for hearing loss. (Ex. 33). On November 22, 1994, Liberty, on behalf of Parkway, issued a responsibility denial, stating that it had requested designation of paying agent under ORS 656.307. (Ex. 51).

There was no argument at hearing that Parkway/Liberty did not receive notice of the claim in May 1994. Parkway/Liberty's denial, which was issued on November 22, 1994, was issued more than 90 days after the initial claim for hearing loss was filed. Parkway/Liberty did not accept or deny the claim within 90 days as required by ORS 656.262(6)(a). Because Parkway/Liberty delayed its denial of the claim and offered no explanation for the delay, we find that its delay was unreasonable. We, therefore, conclude that a penalty for unreasonable conduct may be assessed against Parkway/Liberty, although no amounts are due under the claim against it. *See SAIF v. Whitney*, 130 Or App at 432.

Accordingly, because Parkway/Liberty's failure to accept or deny the claim was unreasonable, we conclude that a penalty of 25 percent of amounts due claimant (from DCFP/Liberty) is appropriate. This penalty (which shall be equally shared by claimant and his counsel) shall be paid by Parkway/Liberty and will be based on the compensation payable by DCFP/Liberty on March 16, 1995 (the date the record closed) as a result of this order.

Penalty - Douglas County Forest Products

On review, claimant argued that he was entitled to a penalty against Douglas County Forest Products (DCFP) for the unreasonable delay in claim processing because it failed to timely process the claim. Claimant noted that DCFP/Liberty had timely processed the claim, but failed to provide a copy to claimant's attorney.

On March 7, 1994, claimant's attorney sent a letter to DCFP, providing notice of an occupational disease claim for hearing loss. (Ex. 19). On March 31, 1994, Liberty, on behalf of DCFP, issued a responsibility denial of claimant's condition, stating it had requested designation of a paying agent pursuant to ORS 656.307. (Ex. 26B). Because DCFP/Liberty's denial was issued within 90 days after the claim was filed, there was no "delay" in claim processing. We conclude that claimant is not entitled to a penalty for unreasonable delay against DCFP/Liberty.

Attorney Fees

On reconsideration, claimant contends that he is entitled to an assessed attorney fee for services at hearing and on Board review. He asserts that the Court of Appeals awarded $5,180 for legal services only at the judicial review level. Claimant requests an assessed attorney fee of $4,500 for services at the hearing level and $3,000 on Board review.

When 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. ORS 656.388(1); *Donald Converse*, 50 Van Natta 2067 (1998). None of the carriers challenge claimant's assertion that the $5,180 fee was for legal services only at the judicial review level. We therefore turn to a determination of a reasonable fee for claimant's counsel's services at hearing and on Board review. Claimant requests an assessed attorney fee of $4,500 for services at the hearing level and $3,000 on Board review. None of the carriers, including DCFP/Liberty, objects to claimant's request for additional attorney fees.

On *de novo* review, we consider the amount of claimant's counsel's attorney fee for services at hearing and on review by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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.

At the December 8, 1994 hearing, claimant withdrew his request for hearing regarding his bilateral hearing loss claim against nine carriers. Claimant pursued his claim against five carriers. The transcript for the December 8, 1994 hearing was 53 pages and the transcript for closing argument was an additional 31 pages. At that hearing, claimant testified on his own behalf and one witness testified on behalf of claimant. The transcript for the February 22, 1995 hearing regarding Murphy/Liberty's motion to reopen the record was 69 pages. Three witnesses testified at that proceeding.

The record included 60 exhibits, 35 of which were generated or submitted by claimant's counsel. The case involved legal issues associated with the last injurious exposure rule in a compensability setting, as well as the disclaimer provisions of *former* ORS 656.308. The issue was more complex than those normally presented to this forum for resolution. Claimant's counsel submitted about 30 pages of argument on Board review, which included a 13-page appellant's brief, an 8-page reply brief, a 7-page motion for reconsideration, and a 2-page reply to Douglas/Liberty's response on reconsideration.

Because claimant's hearing loss condition has been found compensable, he is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The value of the claim may potentially include permanent disability benefits.

The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. Although claimant contends that Murphy/Liberty asserted a frivolous defense by maintaining its compensability denial on appeal, we are not persuaded by claimant's argument. As demonstrated by the extent of litigation, there was a significant risk that claimant's counsel's efforts would go uncompensated. Considering all these factors, we find that $7,500 is a reasonable fee for claimant's counsel's services at hearing and on review concerning compensability of the hearing loss condition.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on Board review is $7,500, payable by DCFP/Liberty. In reaching this conclusion, we have particularly considered the time devoted to the denial issue (as represented by the record and claimant's appellate arguments to the Board), the complexity of the issues, the value of the interest involved, and the risk that counsel might go uncompensated. This award is in addition to the $5,180 awarded for serviices performed before the court, resulting in a total award for services rendered before all prior forums of $12,680, to be paid by DCFP/Liberty. Claimant is not entitled to an attorney fee for his counsel's efforts in seeking an attorney fee. *See Amador Mendez*, 44 Van Natta 736 (1994).

In conclusion, we find that a reasonable attorney fee award for claimant's counsel's services at all levels (including judicial review) is $12,680, to be paid by DCFP/Liberty. Claimant is awarded a 25 percent penalty based on compensation due from DCFP/Liberty as of March 16, 1995, as a result of this order, payable by Murphy/Liberty, to be shared equally by claimant and his attorney. Claimant is also awarded a 25 percent penalty based on compensation due from DCFP/Liberty as of March 16, 1995, as a result of this order, payable by Parkway/Liberty, to be shared equally by claimant and his attorney.

Accordingly, on reconsideration, we adhere to and republish our September 23, 1998 order, as supplemented and modified herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 28, 1998 Cite as 50 Van Natta 2419 (1998)

In the Matter of the Compensation of
SCOTT R. SWINDLEHURST, Claimant
Own Motion No. 98-0485M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for his compensable lumbar strain and lumbar herniated disc at L5-S1, on the left. SAIF initially recommended that we authorize the payment of temporary disability compensation.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

Here, claimant's claim was first closed on October 29, 1993. Claimant's attending physician's request for surgery approval was submitted to SAIF on October 29, 1998, the date his aggravation rights expired.

Under such circumstances, we requested the parties' positions regarding whether this claim was within our own motion jurisdiction pursuant to ORS 656.278. In response, SAIF acknowledges that claimant's aggravation rights were still in effect when it received the request for claim reopening. Consequently, SAIF withdraws the request for Own Motion relief.[1]

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[1] Claimant has not responded to our inquiry nor to SAIF's contentions. We interpret his silence to mean that he does not contest SAIF's acknowledgment that the request for Own Motion relief should be withdrawn because his aggravation rights had not expired at the time of the current worsening.

In light of SAIF's unrebutted concession, we hold that claimant's aggravation rights have not yet expired under ORS 656.273(4). Rather, as implied by SAIF's recent submission, claimant's request for reopening will be processed as a claim for aggravation under ORS 656.273. Consequently, we do not have jurisdiction over this claim.

Accordingly, this request for claim reopening under ORS 656.278 is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER A. CALLAWAY, Claimant
WCB Case No. 98-02686
ORDER ON REVIEW
Black, Chapman, 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) Mongrain's order that upheld the SAIF Corporation's denial of claimant's right shoulder injury claim. On review, the issues are procedural validity/waiver and compensability.

We adopt and affirm the ALJ's order with the following comment regarding claimant's procedural challenge to SAIF's denial.

On December 17, 1997, claimant sustained a work injury that combined with a preexisting right shoulder condition. Claimant filed an injury claim with the employer, and SAIF issued a denial on the express ground that the work injury combined with the preexisting condition but "is not the major cause of the combined condition." On review, claimant asserts that the correct legal standard is whether the work 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)(B) (emphasis supplied). Thus, claimant argues that SAIF's denial is legally invalid because it states an incorrect legal standard.

We decline to address claimant's procedural challenge for the following reason. During the opening colloquy at hearing, counsel for SAIF clearly stated the legal basis of its denial. Specifically, SAIF's counsel asserted that the injury was not the major contributing cause of the "need for treatment of the combined condition" within the meaning of ORS 656.005(7)(a)(B). (Tr. 5 and 6). At that point, claimant had the opportunity to challenge SAIF's position. Claimant failed to do so and proceeded to litigate the merits of the compensability issue. In so doing, claimant waived any potential procedural defect in SAIF's denial. *See Thomas v. SAIF*, 64 Or App 193 (1983).

ORDER

The ALJ's order dated July 31, 1998 is affirmed.

In the Matter of the Compensation of
TIMOTHY W. STONE, Claimant
WCB Case No. 97-06478
ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

On November 18, 1998, we withdrew our October 22, 1998 Order on Review that: (1) found claimant's right foot plantar fasciitis compensable; (2) assessed the SAIF Corporation a penalty for unreasonable claim processing; and (3) awarded an insurer-paid attorney fee under ORS 656.386(1). We took this action to consider SAIF's contention that claimant's request for review should be dismissed because he died while his appeal was pending and left no statutory beneficiaries to pursue his claim. Having received claimant's response and SAIF's reply, we proceed with our reconsideration.

Relying on ORS 656.218(3), SAIF contends that the appeal of this deceased claimant's claim can only be pursued by "persons described in subsection (5) of this section." Noting that subsection (5) refers to ORS 656.204 (which describes a surviving spouse, children - under the age of 18, children - under the age of 19 and a full-time high school student, children under the age of 23 and attending higher education, an invalid, or a dependent), SAIF argues that this request for review must be dismissed because the deceased claimant was not survived by anyone who satisfies the aforementioned statutory description. In support of this assertion, SAIF represents that claimant was survived by his 20-year-old daughter, who has graduated from high school and is not currently pursuing further formal education.

In reply, claimant's counsel does not challenge SAIF's representations regarding the current status of the deceased claimant's surviving child. Rather, claimant's counsel represents that the decedent's child is pursuing the claim as the personal representative of the estate. In that capacity, claimant's counsel argues that the personal representative is not seeking the payment of disability benefits, but is merely requesting payment of medical bills. Claimant's counsel reasons that to prevent such a claim would leave medical service providers without recourse to recover reimbursement for their services.

Although claimant's counsel raises an interesting public policy question, the relevant statutory authority and case precedent does not grant us the necessary latitude to recognize this so-called "medical bill" exception to ORS 656.218. It is well-settled that the right to pursue a deceased claimant's hearing request is limited to statutory beneficiaries, a category that does not include the personal representative of a deceased claimant's estate. *Edwards v. Cherry City Electric, Inc.*, 141 Or App 578 (1995); *Trice v. Tektronix, Inc.*, 104 Or App 461 (1990); *Janet R. Champ*, 46 Van Natta 1050, 1051 (1994).

Claimant's counsel accurately notes that the deceased claimants in *Edwards* and *Trice* were pursuing disability benefits, whereas the primary focus of the present appeal is the compensability of a disputed condition (and ultimately the payment of medical bills). Nonetheless, the applicable statute is not limited to the pursuit of a claim for disability benefits. To the contrary, ORS 656.218(3) expressly provides that "[i]f the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing."[1]

Here, the deceased worker's hearing request sought the acceptance of a plantar fasciitis condition, as well as penalties and attorney fees. Inasmuch as that hearing request was filed pursuant to ORS 656.283, all issues presented by the request are entitled to be pursued by "the persons described in subsection (5)" of ORS 656.218. Because a personal representative is not one of the persons described in the applicable statute and because claimant's counsel does not assert that the decedent's 20-year-old daughter is otherwise entitled to pursue the claim, we conclude that the request for Board review must be dismissed.

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[1] Section (1) of ORS 656.218 provides that "[i]n 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." Inasmuch as "compensation" includes "medical services," *see* ORS 656.005(8), the statutory scheme prescribed in ORS 656.218 applies to this appeal of the ALJ's order arising from the deceased claimant's hearing request under ORS 656.283. *See Trice*, 104 Or App at 465 (in response to argument that ORS 656.218(3) is limited to permanent disability benefits, court notes the Legislature's use of the "more inclusive term" "compensation" in ORS 656.218(1) and, relying on definition of "compensation" in ORS 656.005(8), concludes that statute applies to the disputed temporary disability benefits).

Accordingly, on reconsideration and in lieu of our October 22, 1998 Order on Review, the request for Board review is dismissed.

IT IS SO ORDERED.

Board Chair Bock specially concurring.

I concur with the majority's conclusion that the request for Board review must be dismissed. Although this decision is compelled by the *Trice* court's interpretation of ORS 656.218, I submit that it reaches a result that was unlikely envisioned by the statutory scheme.

In *Trice,* the court rejected an argument from the personal representative of a deceased claimant's estate that ORS 656.218 did not preclude the estate from pursuing the decedent's claim for temporary disability even though the decedent was not survived by a beneficiary under the "death benefit" statute (ORS 656.204). Emphasizing the inclusion of the term "compensation" in the statute, the *Trice* court reasoned that temporary disability was encompassed within the statutory scheme and, as such, the estate's request for such benefits must be dismissed.

Considering the use of the broad and inclusive term "compensation" in ORS 656.218, as further supported by that statutory term's definition in ORS 656.005(8), it is apparent that "medical services" are encompassed within "compensation." Thus, as with the temporary disability request from the deceased claimant's estate in *Trice,* the present request for medical services pursued by this deceased claimant's "beneficiary-less" estate cannot be pursued. Although such reasoning is consistent with the statutory scheme, I submit that this result creates an unjust hardship on this deceased claimant's estate and, potentially, the decedent's medical service providers.

In referring to the persons described in the "death benefit" statute (ORS 656.204) as those persons entitled to pursue a hearing request regarding a deceased worker, ORS 656.218 (in conjunction with ORS 656.204) would appear to be premised on the concept that the statutory beneficiaries of a deceased worker are authorized to recover compensation due the deceased worker as a result of the compensable injury. When such benefits pertain to temporary or permanent disability (*i.e.,* indemnity benefits), it is understandable that, in the absence of a surviving spouse, child, or dependent, a claim for such benefits would be essentially rendered moot.

On the other hand, when, as here, the deceased worker's estate's claim is "compensability-based" (*i.e.,* includes medical services), the recovery of benefits is not entirely confined to reimbursement for a deceased worker's temporary loss of wages or permanent loss of earning capacity. Rather, the estate is also seeking reimbursement for medical expenses attributable to services provided for an allegedly compensable injury. Thus, unlike the situation arising in temporary or permanent disability claims (which are based on a deceased worker's request for an *award* of benefits; that is an *increase* in the estate's value), a "compensability-based" claim attempts to provide *reimbursement* to the estate for payments it has already forwarded to medical service providers or for outstanding bills related to those services.

In the absence of this "medical service" reimbursement, the value of the estate is negatively impacted; *i.e.,* the estate's assets have been depleted and not replenished. In contrast, when the request for an award of "temporary/permanent disability" is dismissed, the value of the estate is not reduced; rather the estate's assets are not increased. Moreover, if the estate is unable to satisfy the deceased worker's obligations, the medical service provider may not receive full payment for its services. Alternatively, if the provider eventually receives reimbursement from another source (whether private or public), the allegedly responsible entity (*i.e.,* the decedent's employer) would effectively have been relieved of its potential liability for medical services resulting from an apparently work-related injury.

In conclusion, I submit that placing claims for medical services within the same category as indemnity death benefits creates an anomalous result and an undue hardship on a deceased worker's "beneficiary-less" estate. To address this apparent anomaly, it is my hope that the legislature will consider amending the statutory scheme to permit a decedent's estate to seek reimbursement for medical bills under circumstances such as are present in this case. In the meantime, because the current statutory structure does not allow such a claim in the absence of beneficiaries under the "death benefit" statute, I am legally obliged to join the majority in dismissing the request for Board review.

In the Matter of the Compensation of
TED B. MINTON, Claimant
WCB Case No. 97-06935
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of his aggravation claim for a rectus muscle strain condition. On review, the issues are issue preclusion, claim preclusion and aggravation. We reverse the ALJ's decision to uphold the denial. Instead, we set aside the denial as a nullity because claimant did not perfect his aggravation claim.

FINDINGS OF FACT

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

In July 1993, claimant, a carpenter, experienced the sudden onset of pain in the left inguinal area. He made a claim, which was accepted as a nondisabling left inguinal strain by the employer's then carrier. Previously, at age 14, claimant had a left inguinal hernia repair.

On April 15, 1994, claimant experienced a recurrence of his left inguinal pain while lifting a heavy object at work. He sought treatment with Dr. Rambousek, an osteopath, who diagnosed a left inguinal strain.

On March 2, 1995, claimant sought treatment from Dr. Rentmeester for anterior abdominal wall pain. Dr. Rentmeester found no evidence of any tear of the rectus muscle or any herniation. He recommended strengthening exercises of the abdominal wall.

Claimant made a claim for a groin muscle strain arising out of the April 1994 incident. On March 14, 1995, the employer's current insurer accepted a nondisabling rectus muscle strain. Claimant continued to treat with Dr. Rambousek for complaints of pain in the left abdominal and inguinal area during this time.

In May 1996, claimant was seen by Dr. Seres, who diagnosed muscle strain of the abdominal wall with no evidence of hernia. In November 1996, claimant came under the care of Dr. McWeeney, an orthopedic surgeon, who similarly diagnosed a left abdominus rectus strain/sprain and advised claimant he would have to live with this condition.

In February 1997, claimant experienced an exacerbation of his symptoms and returned to Dr. Rambousek. Dr. Rambousek diagnosed a left inguinal strain and a left rectus abdominal strain. He took claimant off work and completed a Notice of Aggravation claim form.

In March 1997, claimant was examined by Dr. Braun at the insurer's request. Dr. Braun diagnosed abdominal and groin pain of uncertain etiology. He did not relate claimant's current symptoms to work activities.

The insurer denied the aggravation claim on February 14, 1997, asserting that the request had not been approved by claimant's attending physician of record. Thereafter, on February 20, 1997, Dr. McWeeney completed a Notice of Aggravation claim form, which the insurer denied on March 13, 1997 due to lack of objective findings.

Claimant requested a hearing on the insurer's denials, which was held before ALJ Neal on July 11, 1997. The insurer asserted that claimant had not perfected either aggravation claim under ORS 656.273(3). In a July 30, 1997 Opinion and Order, ALJ Neal found that claimant's aggravation claims were statutorily defective. Alternatively, on the merits, the ALJ found that claimant had not established an actual worsening of his accepted strain. The ALJ dismissed claimant's request for hearing and declared the denials void. The order was not appealed and became final by operation of law.

Meanwhile, claimant began treating with Dr. Davidson, a chiropractor, in late March 1997. Dr. Davidson referred claimant to Dr. Puziss, who evaluated claimant on June 5, 1997. Dr. Puziss found no orthopedic impairment, but noted abnormalities of the rectus abdominous attachment.

On June 20, 1997, claimant requested that the insurer amend its claim acceptance to include a left inguinal strain. The insurer declined to do so, and issued a denial of the left inguinal strain condition on July 1, 1997. That denial has since become final by operation of law.

Thereafter, on August 6, 1997, following the issuance of the ALJ Neal's order, Dr. Rambousek completed another Notice of Aggravation claim form, authorizing time loss from July 1, 1997. In an August 15, 1997 report, Dr. Rambousek opined that claimant's chronic inguinal strain remained unchanged.

On September 12, 1997, the insurer denied claimant's aggravation claim. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, the insurer argued that the merits of claimant's aggravation had been resolved by ALJ Neal's Opinion and Order, and therefore claimant's August 6, 1997 aggravation claim was barred by the doctrines of issue preclusion and/or claim preclusion. Alternatively, the insurer challenged the validity of claimant's August 6, 1997 aggravation claim on procedural grounds, asserting that the claim form was not accompanied by an attending physician's report establishing a worsened compensable condition. The ALJ accepted the insurer's first contention, finding that the doctrine of issue preclusion prohibited relitigation of the merits of the aggravation claim.

On review, claimant contends that the ALJ erred in applying issue preclusion. Specifically, claimant argues that because ALJ Neal's order dismissed claimant's request for hearing and voided the insurer's denials, the parties did not "actually litigate" the substantive merits of the aggravation claim (including whether claimant had established an actual worsening). Claimant also asserts that ALJ Neal's findings as to the merits of the aggravation claim were not essential to the determination that claimant had not perfected his aggravation claims under ORS 656.273(3). Consequently, claimant argues that he is not precluded from proving in this proceeding that he experienced an actual worsening of his accepted condition in February 1997.

The doctrine of issue preclusion bars litigation of an issue if that issue was actually litigated *and* determined in a setting where the determination of the issue was essential to the final decision on the merits. *See North Clackamas School Dist. v. White*, 305 Or 48, 53 (1988). Under the circumstances of this case, we agree with claimant that issue preclusion does not apply. Because ALJ Neal's order dismissed claimant's request for hearing and voided the insurer's denials (based upon the procedural defects in claimant's claims for aggravation), her determination that claimant had not established an actual worsening of his compensable condition was not *essential* to the final decision. Therefore, the doctrine of issue preclusion is not applicable.

We need not decide whether claim preclusion is applicable, however, because even assuming claimant was not precluded from arguing the merits of his aggravation claim,[1] we agree with the insurer's alternative contention that claimant has not perfected a valid aggravation claim.

Under ORS 656.273(3), there are two essential elements for a "claim for aggravation": the completed Director's form and the accompanying attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury. *See David L. Dylan*, 50 Van Natta 276, *on recon* 50 Van Natta 852 (1998); *see also Melvin L. Shroy*, 48 Van Natta 561 (1996). Here, although claimant and Dr. Rambousek submitted a completed Director's form to the insurer on August 6, 1997, the record fails to establish that the claim form was accompanied by the required written medical report. Dr. Rambousek indicated on the Director's form that time loss was authorized from July 1, 1997 and that claimant was limited to bed rest with no lifting, bending or twisting, but we find no companion medical report documenting objective findings of a worsened condition attributable to the accepted rectus muscle strain.

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[1] Unlike issue preclusion, claim preclusion does not require that an issue actually be litigated. Rather, the claim preclusion doctrine applies when there is an opportunity to litigate an issue before a final determination of the proceeding. *Drews v. EBI Companies*, 310 Or 134, 140 (1990); *Popoff v. J.J. Newberrys*, 117 Or App 242 (1992).

Indeed, even if we were to find that the aggravation claim form was "accompanied by" Dr. Rambousek's August 4, 1997 chart note and/or his August 15, 1997 letter to claimant's counsel (documents which were sent to the insurer a few weeks after the August 6, 1997 aggravation claim form), neither report satisfies the statutory requirement. The August 4, 1997 chart note refers to a denied condition (inguinal strain)[2] rather than the accepted condition (rectus muscle strain) and, in any event, does not document any objective findings of a worsened condition. Similarly, Dr. Rambousek's August 15, 1997 letter does not reference the compensable condition, noting instead that claimant's "chronic inguinal strain" condition "has currently remained unchanged."

We recognize that, in prior reports, Dr. Rambousek discussed his findings and indicated that claimant's compensable condition had worsened.[3] But, mindful of the statutory requirement that the aggravation claim form be "accompanied by" an attending physician's report documenting a worsened condition (and the insurer's challenge to the validity of the claim on this basis),[4] we nevertheless find that claimant's August 6, 1997 aggravation claim is procedurally defective.[5]

Because we have found that claimant has not made a valid aggravation claim, the insurer's September 12, 1997 denial is a nullity and without legal effect. *See, e.g., Vicki L. Davis*, 49 Van Natta 603 (1997) (where, in the context of a new medical condition claim, the claimant did not make a "clear request" for a "formal written acceptance" of the disputed conditions as required by ORS 656.262(7)(a), the carrier's denial those conditions had no legal effect, as a denial issued in the absence of a claim is a nullity).

ORDER

The ALJ's order dated June 25, 1998 is reversed. The insurer's aggravation denial is set aside as a nullity.

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[2] As set forth above, the insurer's July 1, 1997 denial of claimant's left inguinal strain condition has become final.

[3] For example, in a July 1, 1997 "check-the-box" report, Dr. Rambousek opined that claimant's accepted strain became pathologically worse because of the rectus muscle scar and tearing, and that claimant's April 1994 injury was the major cause of this worsening.

[4] *Compare Ronda G. Prewitt*, 49 Van Natta 831 (1997) (where the carrier did not specifically challenge the validity of the claimant's aggravation claim on the grounds the claim form was not "accompanied by" an attending physician's report, Board declined to address the issue).

[5] Had the August 6, 1997 aggravation claim form been accompanied by a written report by Dr. Rambousek specifically referencing his prior findings and opinions regarding the compensable condition and its worsening, the requirements of ORS 656.273(3) would have been satisfied. In the absence of an accompanying medical report, however, claimant has not submitted a valid aggravation claim.

In the Matter of the Compensation of
BRIAN S. MacDONALD, Claimant
Own Motion No. 98-0378M
OWN MOTION ORDER OF ABATEMENT
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

On December 23, 1998, we issued our Own Motion Order wherein we declined to reopen claimant's claim based on Administrative Law Judge (ALJ) Howell's Opinion and Order dated November 20, 1998. We took this action because we believed ALJ Howell's order had not been appealed and had become final by operation of law.

It has come to our attention that the SAIF Corporation requested review of ALJ Howell's November 20, 1998 order which we received on December 22, 1998. We acknowledged receipt of SAIF's request for review on December 23, 1998.

Under such circumstances, we conclude our reliance on ALJ Howell's November 20, 1998 order being final was misplaced. Thus, we find it appropriate to withdraw our prior order pending issuance of the Board's Order on Review. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARLENE J. BOND, Claimant
WCB Case No. 97-08279
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) determined that the Department had jurisdiction to address the issue of unscheduled permanent disability; and (2) affirmed an Order on Reconsideration that reduced claimant's award of unscheduled permanent disability from 33 percent (105.6 degrees), as granted by a Determination Order, to 21 percent (67.2 degrees) and reduced the award of scheduled permanent disability in the Determination Order from 9 percent (17.28 degrees) to 3 percent (4.5 degrees). In its respondent's brief, the insurer seeks sanctions under ORS 656.390 for a frivolous appeal. On review, the issues are jurisdiction, scheduled and unscheduled permanent disability, and sanctions.

We deny the insurer's request for sanctions and adopt and affirm the ALJ's order with the following supplementation.

Jurisdiction

We adopt the ALJ's reasoning and conclusion with the following supplementation regarding claimant's challenge to the Department's authority to consider an issue (here, extent of unscheduled permanent disability) not specifically raised by her request for reconsideration.

We have previously held that the Department's review of a timely appealed closure notice is not necessarily limited to only those issues expressly raised by the parties. Cases such as *James E. Clemons*, 50 Van Natta 267 (1998); *Jason O. Olson*, 47 Van Natta 2192, 2194 (1995); *Russell D. Sarbacher*, 45 Van Natta 2230 (1993) and *Darlene K. Bentley*, 45 Van Natta 1719, 1722 (1993) stand for the general proposition that the Department may take whatever authorized action it deems necessary in its reconsideration of a closure notice or Determination Order. *See also Estella Rogan*, 50 Van Natta 205, n.4 (1998) (Department was authorized to address premature closure issue even though issue was not expressly raised by the parties).

Consequently, we agree with the ALJ's determination that the Department was authorized to address the issue of unscheduled permanent disability in this case.

Permanent Disability

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

Sanctions

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

Here, the insurer argues that claimant's raising of an issue regarding an attorney fee pursuant to ORS 656.382(2) was frivolous because the issue had been withdrawn at hearing and because, by its terms, ORS 656.382(2) does not apply to the facts of this case. Although the insurer's assertion has some appeal, our statutory authorization for the imposition of sanctions is confined to a frivolous "request for review," rather than a frivolous argument on review.

Specifically, ORS 656.390(1) allows imposition of a sanction if a "request for review" was frivolous, filed in bad faith or for purpose of harassment. While the particular *issue* of an attorney fee under ORS 656.382(2) may have been raised without reasonable prospect of prevailing, we cannot say that the overall request for review was frivolous; *i.e.*, initiated without reasonable prospect of prevailing. We find that claimant made at least a colorable argument that the Department lacked jurisdiction to reduce her award of unscheduled permanent disability and that she was entitled to reinstatement or an increase of her scheduled permanent disability award.

Accordingly, we conclude that claimant's request for review was not frivolous. Consequently, the insurer's request for sanctions is denied.

ORDER

The ALJ's order dated August 11, 1998 is affirmed.

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[1] That statute provides:

"(1) Notwithstanding ORS 656.236, if either party requests a hearing before the Hearings Division, requests review of an Administrative Law Judge's decision before the Workers' Compensation Board, appeals for review of the claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the Administrative Law Judge, board or court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the Administrative Law Judge, board or court may impose an appropriate sanction upon the attorney who filed the request for hearing, request for review, appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the request for hearing, request for review, appeal or motion, including a reasonable attorney fee.

"(2) As used in this section, "frivolous" means the matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing."

In the Matter of the Compensation of
KENNETH A. MEYER, Claimant
WCB Case No. 97-08075
ORDER OF ABATEMENT
Geoffrey G. Wren, Claimant Attorney
Lane, Powell, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our December 7, 1998 Order on Review that reversed an Administrative Law Judge's (ALJ's) award of procedural temporary total disability (TTD) compensation commencing February 2, 1998. Claimant contends that our decision on this issue was an impermissible advisory opinion.

In order to further consider this matter, we withdraw our December 7, 1998 order. The self-insured employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

December 31, 1998 Cite as 50 Van Natta 2428 (1998)

In the Matter of the Compensation of
THOMAS A. CLARK, Claimant
WCB Case No. 98-00187
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's claim for a left foot condition (contusion/strain/Morton's neuroma). 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

As a preliminary matter, the insurer in its reply brief requests that we strike that portion of claimant's respondent's brief that relies on findings and medical opinion in *Janet A. Robbins*, 45 Van Natta 190 (1993) to establish that a Morton's neuroma can be caused by trauma. We need not strike that portion of the brief because the case cited by claimant has no bearing on the weight of any of the medical opinions in this case and we do not rely on it. *See, e.g., Giesbrecht v. SAIF*, 58 Or App 218 (1982) (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).

Compensability

We begin with a brief summary of the pertinent facts. Claimant has worked for the employer for over fifteen years running a packaging machine. His work requires standing on hard floors for the greater part of his shift. Claimant had no problems with his left foot until September 2, 1997, when he slipped and fell, striking the ball of his left foot on the edge of a stair. Although claimant did not have an immediate onset of pain (Tr. 15), he sought treatment the next morning, complaining of pain at the second and third metatarsals.

Dr. Edwards noted that claimant felt like something was moving around in the ball of his foot. Dr. Edwards found a fluid-filled mass and diagnosed a possible ecchymosis or old hematoma, resolving. Subsequently, Dr. Schader diagnosed a contusion of the left second metatarsal and a Morton's neuroma. After a steroid injection gave little relief, Schader excised the neuroma. The insurer denied claimant's claim for contusion/strain/Morton's neuroma.

Morton's neuroma

The ALJ concluded that claimant's claim consisted of a Morton's neuroma and that it was compensable as a combination injury/occupational disease. On review, the insurer contends that claimant pursued his claim as an injury and not an occupational disease. We conclude that claimant's claim for his Morton's neuroma fails whether analyzed as an injury or an occupational disease.

Claimant's theory is that the September 2, 1997 work incident combined with his work activities over a period of time prior to the injury to cause the development of his Morton's neuroma. (Exs. 26-1, 28-4, 29). Because claimant relies on his work activities over an extended period of time as a contributing factor to the development of his condition, he must prove that his employment was the major contributing cause of his condition. ORS 656.802(2).

Determination of the major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (persuasive medical opinion must evaluate the relative contribution of different causes and explain why the work exposure or injury contributes more to the claimed condition than all other causes or exposures combined). Claimant asserts that he has met this burden of proof. We disagree.

Opinions regarding the major contributing cause of claimant's neuroma condition were provided by Dr. Schader, Dr. Schilperoort, and Dr. Sedgewick. In his reports, Dr. Schader, claimant's attending surgeon, first opined that the neuroma was "the direct result of [claimant's] on-the-job activities at [the employer], due to prolonged standing and walking." (Ex. 15). Schader subsequently opined that both the long hours of standing combined with the blow to his left foot were "directly responsible" for the neuroma formation. (Ex. 26). Schader's final opinion was that claimant sustained *acute traumatic bursitis* in the second intermetatarsal space of his left foot, which led to the formation of the Morton's neuroma, or "interdigital neuritis." Schader also felt that claimant's years of standing on hard surfaces at work "contributed somewhat" to the condition. (Ex. 31).

Dr. Sedgwick also evaluated claimant's left foot. Sedgwick initially diagnosed claimant's condition as a probable reflex sympathetic dystrophy due to the work injury, but that diagnosis was never confirmed. Subsequently, he opined that claimant's Morton's neuroma was not caused by the work injury, as it was unlikely that a neuroma would develop one day after the injury. In this regard, Dr. Sedgwick reported that the "palpable mass" noted the day after the work incident was most probably the neuroma. Sedgwick also opined that the neuroma was just as likely idiopathic or the result of the structure of claimant's foot as caused by his standing and walking at work. (Exs. 20, 29).

Dr. Schilperoort evaluated claimant's foot after the excision of the neuroma. Schilperoort diagnosed an injury-related plantar or metatarsal head contusion. (Ex. 28). He noted that the finding of a fluid filled mass the day after the work incident was consistent with such a traumatic event. (*Id.* at 3). He also separately diagnosed an early-stage Morton's neuroma which he opined was unrelated to claimant's work injury or industrial exposure, because the location of the neuroma deep in the intermetatarsal space protected it from any direct trauma such as claimant's foot injury. He reasoned that claimant's continued post-surgery pain was consistent with a metatarsal head contusion, but that it was inconsistent with a Morton's neuroma excision. Schilperoort also stated that the area in the decussation (crossing) of the nerves (the site of the neuroma) may have been irritated by the post-traumatic hematoma, although he opined that such an irritation would "in no way" cause the neuroma itself. Instead, he opined that the primary cause of the creation of the neuroma is a superflexible flatfoot with recurrent micro trauma at the fork of the sensory nerves between the metatarsal head. (*Id.*)

For the reasons that follow, we are unable to conclude that claimant's injury or his employment activities over time -- or the two factors taken together -- constitute the major contributing cause of claimant's combined condition or the major contributing cause of the need for treatment of the combined condition. The only opinion that arguably supports compensability is that of Dr. Schader. Dr. Schader's opinion has, however, changed over time and is insufficiently explained to be persuasive.

Dr. Schader initially attributed the cause of claimant's Morton's neuroma exclusively to claimant's standing at work. (Ex. 15). Dr. Schader next concluded that claimant's standing at work combined with the work incident on September 2, 1997 and that these two factors were directly responsible for the neuroma formation. (Ex. 26). Dr. Schader's final opinion was that claimant sustained "acute traumatic bursitis" which led to the formation of the Morton's neuroma. (Although not explained, presumably the *acute* traumatic bursitis to which Dr. Schader referred was related to the work incident.) Dr. Schader further stated that claimant's standing at work "probably contributed somewhat to the condition." (Ex. 31).

Although Dr. Schader initially attributed development of the neuroma exclusively to prolonged standing and walking, he subsequently opined that claimant's workplace standing only "contributed somewhat" to the condition. By contrast with his initial opinion, in his final report he appears to place

primary responsibility for development of the neuroma on the traumatic work incident. Although both potential causes are "work-related," he does not provide a medical explanation reconciling these statements. If, as he finally appears to opine, the work incident is the primary contributor to the development of the neuroma, he does not explain the significance of the presence of a fluid filled mass (which Dr. Sedgwick identified as the neuroma) the day following the work incident. Further, he does not adequately respond to Dr. Schilperoort's reasoning that claimant's continued post-operative complaints militate against the conclusion that claimant's symptoms were caused by the neuroma.[1]

Moreover, to the extent that Dr. Schader initially attributes development of the neuroma to claimant's standing and walking at work, he does not respond to Dr. Schilperoort's opinion that the development of claimant's neuroma resulted primarily from a preexisting "hyperflexible flatfoot and splaying of the forefoot." In the absence of some explanation of these factors, we do not find Dr. Schader's opinion persuasive. *Somers v. SAIF*, 77 Or App 259 (1986) (we give more weight to those medical opinions which are both well-reasoned and based on complete information). Because Dr. Schader's opinion is not persuasive, we conclude that, on this record, claimant's left foot Morton's neuroma is not compensable. Accordingly, we reinstate the insurer's denial of this condition and reverse the ALJ's attorney fee award.

Contusion

Unlike the Morton's neuroma issue, the persuasive medical evidence indicates that claimant experienced a contusion as the immediate result of the injury. In this regard, within a short period of time following the work incident, Dr. Gustin noted swelling on the ball of claimant's left foot. (Ex. 5). On first examining claimant, Dr. Schader similarly reported swelling and included a left second metatarsal contusion as a diagnosis. Athough Dr. Schader focused thereafter on claimant's Morton's neuroma, there is no indication that he rejected his initial contusion diagnosis.

Dr. Schilperoort also diagnosed a plantar contusion (resolved) as the direct result of the work incident. He opined that the contusion "based on [claimant's] history is obvious, straightforward, and easily understood." Also supporting a contusion diagnosis, in Dr. Schilperoort's opinion, were the appearance of a fluid filled mass, the location of claimant's pain, and his report of tenderness. Further, as previously noted, Dr. Schilperoort reported that claimant's continued post-surgery pain "is a profile for metatarsal head contusion with inability to toe ambulate, etc. for very prolonged time periods."

In light of this persuasive evidence, we conclude that claimant has established a compensable contusion as a direct result of the September 2, 1997 work incident. To the extent that the insurer's denial included the diagnosed contusion, it must be set aside.

Strain

There is no persuasive evidence that claimant experienced a compensable left foot strain as a result of the work incident. Therefore, this portion of the denial shall be upheld.

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial of his contusion and for successfully defending this portion of the ALJ's order. ORS 656.386(1); 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 assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's left foot contusion injury is $4,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record, claimant's appellate briefs and his counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[1] Although Dr. Schader stated on several occasions that claimant was doing quite well following surgery, these statements are inconsistent with Dr. Schilperoort's more specific notation more than four months after surgery that claimant reported that his overall pain continued to average a "4" on a "0 to 10" pain scale.

ORDER

The ALJ's order dated June 12, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside the insurer's December 22, 1997 denial insofar as it denied compensability of claimant's left foot Morton's neuroma condition is reversed. The insurer's denial of that condition is reinstated and upheld. That portion of the insurer's denial that denied a left foot contusion is set aside. The left foot contusion claim is remanded to the insurer for processing according to law. In lieu of the ALJ's attorney fee award, for services at hearing and on review concerning the left foot contusion condition, claimant's attorney is awarded an assessed fee of $4,000, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JAMES W. FISHER, Claimant
WCB Case No. 98-03110
ORDER ON RECONSIDERATION
Daniel M. Spencer, Claimant Attorney
Zimmerman, Nielsen, et al, Defense Attorneys

Claimant requests reconsideration of our December 14, 1998 Order on Review that adopted and affirmed the Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's low back injury claim. Contending that the "ALJ's order was riddled with inconsistencies and cannot be supported by the record," claimant seeks reconsideration of our decision and reversal of the ALJ's order.

After conducting our reconsideration and reviewing claimant's arguments, we continue to agree with the ALJ's findings and conclusions that, based on inconsistencies between claimant's testimony and other witnesses' testimony, claimant's version of the relevant events lacks credibility. Furthermore, because the medical evidence is dependent on claimant's reliability as a historian, the record does not support a compensable, causal relationship between claimant's low back condition and his work.

In this regard, after our reconsideration, we make the following clarification regarding the weights of the items claimant lifted while loading and unloading the delivery van at work on March 13, 1998, the date claimant alleges he injured his low back. Those items weighed from 20 pounds to 98 pounds and included smaller kitchen cabinets. (Ex. 35, Tr. 89, 107-109). This is significantly less than the 200-300 pounds claimant reported lifting to Drs. Jacobs and Tuft, his treating physicians. (Exs. 5, 9). Moreover, Dr. Tuft agreed that it was significant in forming his medical opinion that he was given a history that claimant was lifting 300 pounds by himself. (Ex. 42-2).

Claimant relies on the medical opinion of Dr. Tuft, as concurred with in a "check-the-box" opinion from Dr. Kendrick, consulting neurosurgeon. (Ex. 40, 41). But that medical opinion is only as reliable as the history upon which it is based. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977). As discussed above, claimant did not accurately report the weights he lifted on the date of the alleged back injury, and the weight reported by claimant influenced Dr. Tuft's medical opinion.

Claimant also notes that Mr. Eckerman, the yard and dispatch supervisor, agrees with him that Ms. Pettyjohn worked with claimant in the afternoon of March 13, 1998, and Ms. Ormsbee worked with him in the morning of that day,[1] whereas Ms. Pettyjohn and Ormsbee testified to the reverse working order. Claimant relies on this point of agreement with Mr. Eckerman and the fact that the ALJ found Mr. Eckerman's testimony most reliable to argue that claimant's testimony is persuasive, whereas the testimony of Ms. Pettyjohn and Ormsbee is not. We do not agree that this discrepancy makes the entire testimony of Ms. Pettyjohn and Ormsbee unpersuasive.

Claimant testified that he told Ms. PettyJohn that he injured his back on March 13, 1998. However, both Ms. Pettyjohn and Ormsbee denied that claimant told them about any injury and denied that claimant showed any signs of having injured his back that day. (Tr. 43, 48-49, 57-58, 88-89, 93-94).

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[1] Ms. Pettyjohn and Ms. Ormsbee are co-workers whose jobs include driving the delivery vans and helping to unload the vans.

Moreover, although relying on Mr. Eckerman's testimony on that one point of agreement, claimant overlooks the fact that Mr. Eckerman's testimony does not support claimant's version of the facts. Contrary to claimant's testimony, Mr. Eckerman: (1) denied that claimant reported any injury occurred on March 13, 1998 during his March 16, 1998 meeting with claimant and testified that claimant showed no indication of any back injury during that meeting; (2) denied that the March 16, 1998 meeting was scheduled for claimant to tell Mr. Eckerman about the events of March 13, 1998; (3) testified that the March 16, 1998 meeting had been scheduled weeks earlier; and (4) testified that he told claimant that he would not be kept on beyond his 90-day probationary period, at which time claimant said he was having a nervous breakdown and began crying. (Tr. 23-24, 34, 100, 101, 102, 103). In contrast, claimant testified that: (1) the March 16, 1998 meeting was scheduled that morning at his request, and during the meeting he told Mr. Eckerman about the March 13, 1998 injury; (2) he talked to Mr. Eckerman about continuing his employment and his ideas about improving his job; (3) Mr. Eckerman never told claimant that he was not going to be kept on after his probationary period and claimant never said he was having a nervous breakdown, nor did he cry. (Tr. 63-64, 76, 79, 80).

Mr. Palotay, the manager, testified that the March 16, 1998 meeting had been scheduled weeks earlier and that he and Mr. Eckerman had decided that they would not keep claimant on beyond his 90-day probationary period. (Tr. 106-07).

Claimant argues that "[r]egardless of the testimonies of all of the witnesses, the unrebutted evidence clearly showed claimant worked for the employer on March 13, 1998." Claimant argues that, based on this work, claimant's doctors related his condition and need for treatment to his employment. Nevertheless, the fact that claimant worked on the date in question does not establish that he was injured at work.

Furthermore, given the multiple inconsistencies addressed above and by the ALJ, we continue to agree with the ALJ that the record establishes that claimant is not a reliable historian. Any medical opinion based on claimant's unreliable history is itself unpersuasive. *Miller v. Granite Construction Co.*, 28 Or App at 476. Therefore, we continue to find that claimant failed to establish a compensable low back injury claim.

Accordingly, we withdraw our December 14, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our December 14, 1998 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 31, 1998 Cite as 50 Van Natta 2432 (1998)

In the Matter of the Compensation of
JACK R. HUNTINGTON, Claimant
WCB Case No. 97-08136
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its "back-up" denial of his left inguinal hernia condition; and (2) assessed a penalty for the insurer's allegedly unreasonable "back-up" denial. On review, the issues are "back-up" denial, 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

"Back-Up" Denial

We adopt the ALJ's reasoning and conclusions regarding the "back-up" denial issue. Thus, it is not necessary to address compensability.

Penalties

Because the insurer issued an improper "back-up" denial, the ALJ concluded that the denial represented unreasonable claims processing. Therefore, the ALJ assessed a penalty of 25 percent of the amounts then due as of the date of hearing. The insurer argues that, even if we find its "back-up" denial improper, its issuance of that denial was not unreasonable. Thus, it argues, no penalties should be assessed. We agree with the insurer.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Here, when the insurer issued the "back-up" denial, it had received a record review report from Dr. Battalia, M.D., who stated that the left inguinal hernia should not have been accepted. (Ex. 57). Dr. Battalia explained that the left inguinal hernia had been diagnosed as an indirect hernia and, if that diagnosis was correct, there was a 96 percent chance of it being congenital. He opined that the major contributing cause of the left hernia was the presence of a congenital sac, not the work activities. (Ex. 57-2). In light of this report, we conclude that the insurer had a legitimate doubt as to its liability for claimant's left inguinal hernia.

Furthermore, after issuing the "back-up" denial, Dr. Barnhouse, claimant's attending physician, indicated that he concurred with Dr. Battalia's opinion. (Ex. 60). Therefore, the basis of the insurer's legitimate doubt as to its liability was not removed after it issued the "back-up" denial.

Although we agree with the ALJ that the "back-up" denial must be set aside, we cannot conclude under these circumstances that the insurer's conduct in this regard was unreasonable. Accordingly, we do not assess a penalty against the insurer for an unreasonable "back-up" denial. *Raymond J. Suek, Sr.*, 49 Van Natta 706, 710 (1997), *aff'd mem* 153 Or App 125 (1998); *Clive G. Osbourne*, 47 Van Natta 2291 (1996).

Attorney Fees on Review

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

ORDER

The ALJ's order dated May 13, 1998, as reconsidered on July 30, 1998, is reversed in part and affirmed in part. We reverse that portion of the order that assessed a penalty against the insurer for allegedly unreasonable claims processing. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

[1] We note that claimant's attorney submitted a statement of services on review and requested an assessed fee of $1,400 for services before the Board related to the issues of the propriety of the insurer's "back-up" denial and penalties. Even if claimant had prevailed concerning the penalty issue, he is not entitled to an attorney fee on review for defending a penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986). We considered these factors in determining a reasonable attorney fee for services on review.

In the Matter of the Compensation of
GREG A. KARR, Claimant
WCB Case Nos. 97-09666 & 97-09383
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found claimant entitled to temporary disability; and (2) assessed a penalty for allegedly unreasonable failure to pay temporary disability. On review, the issues are entitlement to temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has an accepted claim for left knee laceration. In November 1997, an Order on Reconsideration rescinded a Notice of Closure on the ground that the claim was prematurely closed.

On November 13, 1997, claimant was treated by Scott Beyer, physician's assistant to Dr. Grewe. A Form 829 indicated that modified work was authorized beginning November 13, 1997. (Ex. 27).

On December 2, 1997, the insurer wrote to Dr. Grewe asking when claimant would be released to modified work; the response provided was "11/13/97." (Ex. 29-1). Dr. Grewe signed his name and dated it "12/15/97." (*Id.* at 2). An accompanying form indicated that claimant could perform medium work and provided limitations. (*Id.* at 3). Dr. Grewe did not sign the form.

On December 18, 1997, claimant saw Mr. Beyer; the chartnote states that claimant could "continue at light-work level[.]" (Ex. 30).

The insurer, on December 22, 1997, then wrote to claimant that his attending physician had released him for light duty and offered him a light duty job. (Ex. 30A). Claimant did not respond to the offer.

Claimant received temporary disability until December 25, 1997.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Temporary Disability

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

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

Penalties

The ALJ imposed a penalty after finding that the insurer's termination of temporary disability was unreasonable. In so finding, the ALJ acknowledged that the "record does not readily reveal the correct rate of compensation for temporary disability" but decided that it was not necessary to make such a determination.

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.*

By adopting and affirming that portion of the ALJ's order concerning temporary disability, we agreed with the ALJ that a physician's assistant release to modified work does not satisfy ORS 656.268(3). In assessing a penalty, however, we examine whether the insurer had "legitimate doubt" as to claimant's entitlement to temporary disability in light of the authorization from Mr. Beyer, the physician's assistant, releasing claimant to modified employment.

We conclude that the authorization did provide "legitimate doubt." In this regard, we note the absence of Board and court cases addressing this particular issue. Furthermore, there was correspondence from the attending physician indicating that he agreed with the authorization. (Ex. 33). Thus, we find that the insurer's termination of temporary disability was not unreasonable. *See* ORS 656.262(11)(a). Accordingly, that portion of the ALJ's order is reversed.

ORDER

The ALJ's order dated July 10, 1998, as amended July 30, 1998, is affirmed in part and reversed in part. That portion assessing a penalty is reversed. For services on review concerning entitlement to temporary disability, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
ROBERT W. LYTSELL, Claimant
WCB Case No. 98-03490
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Sather, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) increased claimant's unscheduled permanent disability award for cervical and psychological conditions from 66 percent (211.2 degrees), as awarded by an Order on Reconsideration, to 72 percent (230.4 degrees); and (2) awarded 14 percent (21 degrees) scheduled permanent disability for loss of use or function of claimant's right hand and 14 percent (21 degrees) scheduled permanent disability for loss of use or function of claimant's left hand, whereas an Order on Reconsideration had awarded no scheduled permanent disability. On review, the issues are the extent of scheduled and unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's opinion and conclusions regarding claimant's unscheduled permanent disability. We modify the ALJ's scheduled permanent disability award as follows.

The ALJ found claimant entitled to 14 percent scheduled permanent disability awards for each arm, based on the medical arbiter's valid findings of reduced sensation bilaterally in digits three through five.

The employer contends that claimant is entitled to no scheduled permanent disability, or alternatively, that his award should be reduced to 7 percent for each arm.

The employer argues that the medical arbiter's failure to specifically relate sensory findings to the compensable injury raises a "presumption of noncorrelation."[1] But the medical arbiter's instructions required him to make findings of impairment "resulting from the accepted condition(s)," (Ex. 44-2), and he specifically indicated that claimant's findings (including "two-point discrimination") were valid. (Ex. 50; *see* Ex. 45-2). Under these circumstances, the lack of consistent prior lost sensation findings does not constitute a preponderance of medical opinion establishing a different level of impairment. *See* OAR 436-035-0007(9) (WCD Admin. Order 96-072). Accordingly, we agree with the ALJ that claimant is entitled to bilateral scheduled permanent disability awards, based on the medical arbiter's lost sensation findings.[2]

However, we agree with the parties that claimant's scheduled permanent disability is correctly calculated as follows:

Claimant's reduced bilateral sensation at one centimeter in digits three through five is "less than normal," valued at 25 percent impairment of each finger. OAR 436-035-0110(1)(a) & (c). Twenty-five percent impairment of the middle finger is converted to 4 percent of the hand; 25 percent of the ring finger is converted to 2 percent of the hand; and 25 percent of the little finger is converted to 1 percent of the hand, for a total of 7 percent scheduled permanent disability for each hand. OAR 436-035-0070. The ALJ's order is modified accordingly.

Finally, because claimant successfully defended against the employer's request for review seeking reduction or disallowance of claimant's unscheduled permanent disability award, claimant is entitled to an employer-paid attorney fee under ORS 656.382(2) for services on review regarding that issue.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review for successfully defending against the employer's request for reduction of his unscheduled permanent disability award is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the "unscheduled reduction" issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 13, 1998 is modified in part and affirmed in part. Those portions of the order that awarded 14 percent (21 degrees) scheduled permanent disability for loss of use or function of claimant's right hand and 14 percent (21 degrees) scheduled permanent disability for loss of use or function of his left hand are modified. In lieu of the ALJ's award, claimant is awarded 7 percent (10.5 degrees) for loss of use or function of each hand. The ALJ's out-of-compensation attorney fee is modified accordingly. For services on review regarding the self-insured employer's attempt to reduce claimant's unscheduled permanent disability award, claimant's attorney is awarded a $1,200 attorney fee, payable by the employer. The remainder of the order is affirmed.

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[1] The employer argues that the medical arbiter's impairment findings are not reliable, because the arbiter did not provide a written rationale based on sound medical principles explaining why the findings are *valid*, pursuant to OAR 436-035-007(27). But the rule refers to written explanations for *invalid* findings. The rule does not require the arbiter to further explain findings that he or she determines to be valid.

[2] If a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury and does not attribute the impairment to causes other than the compensable injury, such findings may be construed as showing that the impairment is due to the compensable injury. *SAIF v. Danboise*, 147 Or App 550, 552-53, *rev den* 325 Or 438 (1997).

In the Matter of the Compensation of
WAYNE L. REED, Claimant
WCB Case No. 97-09379
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its denial of claimant's injury claim for a thoracic strain and compression fractures; (2) assessed a penalty for the insurer's allegedly unreasonable denial; and (3) awarded a $5,000 assessed attorney fee. On review, the issues are compensability, penalties and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

Claimant worked on the employer's ranch operating machines that cut and baled hay. Claimant also performed some maintenance of the machines. On August 23, 1997, claimant was changing a flat tire on the bale retrieving machine when he felt a pop in his back and pain between the shoulder blades. He finished his shift and went home. The next day was his day off. The following day, Monday morning, claimant awoke with severe pain under the left shoulder blade and down the left arm and the front of his chest. He had trouble breathing.

Claimant told the employer that he was going to see a doctor. He did not mention a work injury at that time. He drove to the town of Adrian, Oregon, and could not drive any further. Claimant told paramedics in Adrian that he thought he was having a heart attack. The paramedics called an ambulance, which took claimant to the hospital.

At the hospital, claimant was tested for a cardiac condition. The emergency room physician's admitting impression was "Chest pain. Rule out MI. There is also a musculoskeletal component for this." (Ex. 3-1). Claimant did not give the emergency room physician a history of an injury at work on August 23, 1997. No cardiac condition was identified. Claimant was discharged from the hospital. The emergency room physician noted that claimant was "discharged in a somewhat belligerent state unwilling to have proper follow-up." The doctor had wanted claimant to stay at the hospital longer, but claimant became concerned about the expense of his hospital treatment and left.

On August 27, 1997, claimant filed a claim indicating that he injured a nerve at work which caused a heart attack. The date of injury on the claim form was given as August 23, 1997.

The insurer denied the claim for a heart attack and left scapular pain on September 24, 1997.

At the hearing, although the condition denied was a heart attack, the parties agreed to litigate compensability of thoracic strain and compression fractures at T7 and T8. (Tr.18-19).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's thoracic conditions were compensable and resulted from the August 23, 1997 injury while changing the tire on the bale retrieving machine. In addition, the ALJ found that the employer's denial was unreasonable and assessed a penalty pursuant to ORS 656.262(11). The ALJ also awarded a $5,000 assessed attorney fee pursuant to ORS 656.386(1).

Credibility/Compensability

On review, the insurer argues that claimant did not sustain an injury at work on August 23, 1997. Instead, the insurer asserts that claimant awoke on the morning of August 25, 1997 with chest and left arm pain and believed he was having a heart attack. The insurer argues that claimant decided to fabricate the injury and file a workers' compensation claim after learning how expensive his cardiac testing had been.

To establish a compensable injury, claimant must first show that he sustained an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a).

The ALJ found claimant credible based on his demeanor. While we generally defer to an ALJ's credibility finding when it is based on the ALJ's ability to observe the witness, if other inconsistencies in the record raise sufficient doubts regarding material testimony, we are not required defer to an ALJ's credibility finding. *See, e.g., Mildred D. Mitchell*, 50 Van Natta 905 (1998).

Here, the insurer argues that claimant is not credible regarding the injury because some of claimant's symptoms were inconsistent with a thoracic strain and because claimant did not report the work incident to the ambulance personnel, the emergency room physician, Dr. Stoune, or to the employer.

Although claimant did not report the injury to hospital or ambulance personnel or to the employer prior to leaving for the hospital, for the following reasons, we find that the preponderance of the evidence supports a conclusion that an incident occurred at work on August 23, 1997.

Claimant awoke on August 25, 1997 with severe pain in his chest and left arm which he suspected might be a heart attack. After reviewing the record, we find that claimant's chest and left arm complaints on August 25, 1997 are consistent with the August 23, 1997 injury described by claimant. In this regard, the medical evidence is persuasive that musculoskeletal pain from an injury could be mistaken for pain from a heart attack.

The emergency room physician, Dr. Stoune, noted that there was a "musculoskeletal component" to claimant's pain. Dr. DeMots, a cardiologist who performed a records review on behalf of the insurer, opined that claimant probably had some coronary artery disease because of his history of smoking, but that there was no indication that the coronary artery disease had reached such a level of severity to cause clinical symptoms. Dr. DeMots stated that other causes for chest pain symptoms such as those claimant experienced are *musculoskeletal pain* and gastrointestinal pain. Claimant's chiropractor, Dr. Williams, also stated that musculoskeletal injuries sometimes mimic coronary symptoms.[1]

After reviewing the medical evidence, we find that it is likely that claimant was suffering from a musculoskeletal injury to the thoracic region and that he mistook the symptoms of the injury for a heart attack. Moreover, because claimant felt the severe pain was due to a heart attack rather than the injury two days previously, we do not find it surprising that he did not initially mention the tire changing incident to the employer, the paramedics or the emergency room personnel. Furthermore, there is no evidence that claimant has a cardiac condition or suffered a heart attack or that he sustained any off-work injury that would account for his symptoms. We note that testing performed at the hospital failed to reveal any cardiac condition.

After a *de novo* review of the record, we find that it is likely that claimant's chest pain was due to another cause such as a musculoskeletal injury. Given this record, we find claimant's complaints on August 25, 1997 to be consistent with his claimed injury. Thus, we are unable to find that his testimony regarding how his thoracic injury occurred is not credible. We are persuaded that claimant injured his thoracic spine on August 23, 1997 while changing a tire on the bale retrieving machine.

Having found that an incident occurred at work on August 23, 1997, we now turn to the issue of whether claimant has established compensability of his thoracic conditions. Given claimant's history of a 1975 noncompensable accident which reportedly involved a spinal fracture, and the confusion regarding the nature of claimant's chest and left arm symptoms, we find that the causation issue in this case presents a complex medical question which requires expert medical evidence for its resolution. *Uris v. Compensation Department*, 247 Or 420 (1967).

The insurer argues that claimant had previously injured his thoracic spine in 1975 in a non-work related motor vehicle accident and asserts that the compression fractures at T7 and 8 are old fractures

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[1] Dr. Weiss also opined that claimant's symptoms could be consistent with thoracic compression fractures. However, for reasons given later in this order, we find Dr. Weiss' opinion unpersuasive.

that are unrelated to the August 23, 1997 work injury.[2] Claimant acknowledged that he injured his back in 1975, but testified that he believed the injury was to his low back.

Dr. Snyder opined that x-rays suggested that the compression fractures at T7 and T8 were old. However, Dr. Snyder also indicated that he was unable to determine the age of the compression fractures from the x-ray. The March 9, 1998 x-ray report by Dr. Gambino, radiologist, states: "Evidence of partial compression of the T7 and T8 vertebral bodies raising the question of remote trauma." (Ex. 15). This x-ray was taken 6 months after the work incident. The insurer also notes that a chart note dated September 3, 1997 indicates that claimant was "prediagnosing himself" with a "vert. fx." (Ex. 8). The insurer suggests that the fact that claimant already knew he had a vertebral fracture and "prediagnosed" the fracture indicates that the condition was likely caused by the 1975 motor vehicle accident.

Dr. Rich examined claimant on behalf of the insurer. Claimant told Dr. Rich that he had previously fractured his back in a 1975 motor vehicle accident, but could not remember the level of the fracture. Dr. Rich concluded that there did not seem to be any evidence of a preexisting mid thoracic condition and diagnosed claimant's condition as a mid back strain with persisting pain complaints.

Claimant testified that the 1975 injury was to the lower part of his back and involved a fracture. An MRI of claimant's lower back did not reveal a prior fracture.

Dr. Weiss opined that claimant's thoracic compression fractures could have caused the chest pain that claimant experienced. In addition, Dr. Weiss presumed that claimant's compression fractures resulted from the work injury. However, Dr. Weiss apparently did not have a history that the 1975 injury had caused a spinal fracture. Under such circumstances, we do not find Dr. Weiss' opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinion based on inaccurate history unpersuasive).

Based on this record, we find a failure of proof with regard to the compensability of the thoracic fractures. Claimant was unsure of the level of the 1975 fracture when he was examined by Dr. Rich. The only fractures demonstrated on x-rays are the thoracic fractures. Claimant testified that the 1975 accident involved the lumbar spine, but an MRI of the lumbar spine did not reveal any old fractures. The x-ray report by Dr. Gambino and Dr. Snyder's opinion suggest that the thoracic fractures are old or are the result of "remote trauma." We cannot determine, in the absence of expert evidence, whether remote trauma could include the work injury 6 months prior to the x-ray report, or whether remote trauma as used by the radiologist would include the 1975 motor vehicle accident. Under these circumstances, claimant has not established that the compression fractures resulted from the August 23, 1997 injury rather than from the 1975 noncompensable injury.

With regard to the thoracic strain condition, we rely on the opinion of Dr. Rich. There is no evidence that the compensable injury combined with a preexisting condition. Thus, claimant can establish compensability of the thoracic strain if the work injury is a material contributing cause of claimant's disability and need for treatment. *Mark Weidle*, 43 Van Natta 855 (1991). Dr. Rich was aware that the 1975 injury caused a spinal fracture. Accordingly, we find that he had an accurate history. We find that Dr. Rich's opinion as a whole supports a conclusion that the August 23, 1997 work injury was a material contributing cause of a thoracic strain.[3] Moreover, Dr. Rich's opinion is supported by the

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[2] The insurer has attached pages from a book entitled "Practical Orthopedics" to its brief. The pages from the orthopedics book were not admitted into evidence at hearing. The insurer relies on this extra-record evidence to establish that a Jewett brace, which claimant testified he wore for the 1975 noncompensable car accident, was worn to treat an injury to the dorsal spine rather than the low back as claimant testified. We treat the submission of the pages from the orthopedics book as a motion for remand for the taking of additional evidence. Because the insurer has not established that the pages were unobtainable at the time of hearing with the exercise of due diligence, we deny the motion for remand. *See Compton v. Weyerhaeuser Co.*, 301 or 641 (1986) (To merit remand for the consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing). Accordingly, we do not consider the extra-record evidence in reaching our decision.

[3] Although Dr. Rich does not explicitly say that the work injury is a material contributing cause of the thoracic strain, we find that his report supports such a conclusion. *See McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986) (a physician is not required to use "magic words" in a medical report).

opinion of Dr. Williams, claimant's chiropractor, who opined that claimant's symptoms were caused by the work incident. Thus, we find claimant's thoracic strain condition compensable.

In summary, although we find the record sufficient to establish compensability of the thoracic strain which was diagnosed by Dr. Rich, we are unable to conclude, based on this record, that claimant has established compensability of the thoracic spine compression fractures. Accordingly, we set aside the insurer's denial to the extent that it denies a thoracic strain and uphold the denial to the extent that it denies the thoracic compression fractures at T7 and T8.

Penalty

The ALJ assessed a 25 percent penalty against the insurer for an allegedly unreasonable denial. We reverse.

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.*

Claimant's initial claim was for a heart attack. There is no evidence that claimant ever suffered a heart attack. Thus, the employer had a reasonable doubt as to its liability for the heart attack.

At the hearing, the parties agreed to litigate the compensability of a thoracic strain and thoracic spine fractures. As we discussed above, the evidence does not establish compensability of the thoracic fractures, and we have sustained the insurer's denial with regard to that condition. Thus, we find that the insurer had a legitimate doubt regarding its liability for the T7 and T8 compression fractures. Furthermore, there are no "amounts then due" upon which to base a penalty. *See* ORS 656.262(11)(a).

With regard to the thoracic strain, we find that the insurer had a legitimate doubt concerning the occurrence of the August 23, 1997 injury. In this regard, claimant did not mention the injury to the employer, the paramedics or the hospital staff. Claimant did not report the injury or file a claim until after being released from the hospital. Although we have found that it was understandable that claimant would not think of the injury when he believed the pain was caused instead by a heart attack, claimant's failure to give a history of the injury gave the employer a legitimate doubt regarding its liability. Accordingly, we reverse the ALJ's penalty award.

Attorney Fees

The ALJ awarded a $5,000 attorney fee pursuant to ORS 656.386(1), considering the factors set forth in OAR 438-015-0010(4). In doing so, the ALJ applied "a factor of 2.5 as a multiplier taking into consideration that is the rate of risk" of not prevailing over a denial based on records of the Department of Consumer and Business Services.

The insurer argues that the attorney fee is excessive and questions the calculation of the "multiplier" applied by the ALJ. The insurer contends that the fee should be $3,200. Claimant argues that the fee awarded by the ALJ was reasonable and has submitted a statement of services documenting the time spent on the case at the hearing and Board review levels.

We have previously declined to apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Marlo D. Thomas*, 50 Van Natta 1538 (1998). 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. In addition, subsequent to the ALJ's order, we held that the Department's records did not represent agency decisions or orders and, as such, were not subject to administrative notice. *Carrie Newton*, 50 Van Natta 1750, 1753, n. 1 (1998).

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 thoracic strain and thoracic compression fractures at T7 and T8. We have set aside the insurer's denial only with regard to the thoracic strain condition. Claimant's attorney has submitted a statement of services indicating he spent 13.4 hours on the case through the July 1, 1998 hearing.

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 include compensation for medical services and potentially temporary and permanent disability benefits. 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 insurer's vigorous defense.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,200 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 thoracic strain/compensability issue (as represented by the record and claimant's attorney's statement of services), 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 thoracic strain is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. In determining a reasonable fee, we have also considered the fact that only the thoracic strain condition has been found compensable and that the denial has been upheld with regard to the thoracic fractures.

Claimant's attorney is not entitled to an attorney fee for services devoted to the penalty and attorney fee issues 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 July 27, 1998 is affirmed in part, reversed in part and modified in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's thoracic fractures at T7 and T8 is reversed. The denial is upheld to the extent it denies the T7 and T8 fractures, but remains set aside with regard to the thoracic strain condition. The ALJ's award of a penalty is reversed. The ALJ's attorney fee award is modified. In lieu of the ALJ's award, claimant is awarded $3,200 for the hearing level, to be paid by the insurer. For services on Board review, claimant's attorney is awarded $800, to be paid by the insurer.

In the Matter of the Compensation of
JOHN W. RICE, Claimant
WCB Case No. C8-02894
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On December 15, 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 4, lines 3 and 4, the proposed CDA provides: " * * * * the claimant retains those rights which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.273 and 656.278."

In *Elizabeth Heller*, 49 Van Natta 570 (1997), we addressed a CDA that provided that the claimant "retains those rights which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.278." We noted that under ORS 656.278(1)(a), the Board may authorize the payment of temporary disability compensation where there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. However, we further reasoned that the Board lacks authority to authorize the payment of medical benefits, except where the date of injury is earlier than January 1, 1966. ORS 656.278(1)(b).

Moreover, we noted in *Heller* that a request for temporary disability under ORS 656.278 will be denied where a claimant has released her rights to all past, present and future temporary disability compensation in a CDA. *See Alka Thornsberry*, 49 Van Natta 569 (1997). Because the claimant had released her rights to past, present and future temporary disability benefits in the CDA, we determined that a request for such benefits under ORS 656.278 would be denied.

In *Heller*, we concluded that the CDA was inaccurate to the extent that it attempted to retain rights "which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.278" since the Board has no such authority to reopen a claim for "curative treatment under ORS 656.278." Finally, to the extent that the claimant may have been attempting to retain her rights to curative care under ORS 656.245(1)(c)(L), we noted that this was unnecessary since a claimant cannot release her rights to those medical services in a CDA. *See* ORS 656.236(1) (unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services).

Here, the CDA refers to ORS 656.273, as well as ORS 656.278, and attempts to "retain those rights which give the Workers' Compensation Board the right to re-open the claim for curative treatment pursuant to ORS 656.273 and 656.278." Because claimant has released his rights to temporary and permanent disability, it is not accurate to say that he retains his right to have the claim "reopened" pursuant to ORS 656.273, since a reopening under that statute can involve the payment of temporary and possibly permanent disability benefits. Likewise, as explained in *Heller*, it is inaccurate to say that claimant retains his rights to "Re-opening" under ORS 656.278. To the extent that these provisions are an attempt to retain claimant's rights to medical treatment for the compensable injury, however, those rights cannot be released in the CDA and are preserved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH R. SMITH, Claimant
WCB Case No. 97-09082
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's claim for a coccyx injury. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation.[1]

Claimant has performed physical labor for the employer for about seven years. At the time of hearing, her job involved installing side bars, fender flares, and bumpers on Toyota trucks. (Tr. 17). In June 1992, while working, claimant fell five or six feet into the "pit" under a vehicle. She hit her head and neck on metal steps and her "butt" on the edge of a ramp upon landing. (Tr. 18-20). Claimant did not miss work time (the injury happened on a Friday), but her pain was excruciating and she took Demerol to keep working. After about a month, claimant's symptoms lessened, but they worsened in 1993 and 1994, without ever having subsided. (Tr. 21-22). She did not seek medical treatment for her tailbone or low back until 1995, when her pain became unbearable. (*Id*). The employer accepted claimant's then-current claim for a "bilateral cervical muscle spasms." (Ex. 4). Claimant's low back complaints at the time were thought to be attributable to a lumbar strain. (*See* Ex. 18, 19).

By early 1995, claimant's relevant symptoms were located in "the gluteal region," "low back and buttocks," "over the sacrum," "L5-S1 and over the mid-body of the sacrum," and gluteus muscles. (Exs. 5, 6, 11, 14, 15). Her condition is currently diagnosed as coccydynia or sacrococcygeal pain. The mechanism of injury was "direct force to the sacrococcygeal joint." (Ex. 77; *see* Ex. 62A-13-16). (The tailbone is the segment of the spine below the sacrum. (Ex. 83-1; *see* Ex. 62A-15-16).)

The employer argues that claimant's coccydynia (painful tailbone) condition is not compensable and the 1992 fall could not have caused her current problems, primarily because claimant's testimony regarding continuous symptoms is not credible. The employer specifically contends that this testimony is impeached by claimant's March 23, 1995 reporting to Dr. Bald and her April 7, 1997 reporting to Dr. Hryekewicz.[2] (Exs. 20, 52A). We disagree.

Dr. Bald examined claimant on May 23, 1995, "only regarding the results of a reported injury," *i.e.*, "chronic cervicothoracic and lumbar strain" conditions. (Exs. 20-1, -5). Dr. Bald found claimant's subjective complaints consistent with her objective finding. (Exs. 20-6). He concluded that claimant's "current symptoms and need for treatment are a direct result of her work activity." (Ex. 20-5; *see* Ex. 20-6).

Dr. Bald examined claimant again on March 3, 1998. (Ex. 72). He reported: "Today [claimant] relates that the soreness in her tailbone went away after approximately one month and when she had no symptoms whatsoever, she did not pursue it." (Ex. 72-1). Dr. Bald was unable to relate claimant's current problems to the 1992 injury, because claimant

> "herself relates that her symptoms at that point in 1992 resolved after approximately a month and that she did not have any significant pain complaints of [sic] symptoms of any kind until the summer of 1994. I cannot associate any lower back or tailbone symptoms in 1994 with an injury that reportedly occurred in 1992 that resolved within a month." (Ex. 72-8; *see* Ex. 72-11).

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[1] We do not adopt the first full sentence on page 4. (*Cf.* Ex. 75-2). In addition, the last sentence of the third full paragraph on page 2 is modified to read: "By 1994, claimant's tailbone pain was unbearable, and she sought treatment *in early 1995*." (*See* Exs. 5, 6, 11, 15).

[2] The employer also argues that claimant is not credible because she told Dr. Laycoe that she "had occasional episodes where she has fallen on her tailbone." (Ex. 40-2). Claimant denies giving this history and we have no reason to suspect that she had more than one tailbone injury. (*See* Tr. 23, 27-8).

But nothing else in the record suggests that claimant had or reported "no symptoms whatsoever" a month after her fall at work.[3]

Dr. Bald's current opinion is also based on a belief that claimant "had no symptoms referable to her low back or to her tailbone or anything else in that area" when he examined her in 1995. (Ex. 83-2, p. 6, *see* pp. 8, 12). But Dr. Bald's own report contradicts this belief. In the 1995 report, Dr. Bald recorded upper and lower back pain, including aching pain "in the right posterior *buttock area* and pressure in this region as well," and tenderness "restricted to the *midsacral* region in the midline, as well as into the *buttock* area and external rotators of both hips." (Exs. 20-3, -5).

Under these circumstances, and particularly considering claimant's credible testimony that her tailbone symptoms never resolved,[4] we cannot say that Dr. Bald's reasoning and conclusions are based on an accurate history in this regard. Moreover, assuming that claimant had unrelenting pain since the 1992 injury, Dr. Bald's opinion would be that the injury *did* cause her coccygodynia in 1998. (Ex. 83-2, pp. 7-8; *see also* Ex. 84-16-17).

Finally, we note that this case is medically unusual and complicated. (*See e.g.*, Exs. 72-8; 83-1). Although the injury happened in 1992, no medical evidence related claimant's disability and need for treatment to the injury until 1997. Nonetheless, based on the entire record, we are persuaded that the diagnostic delay is largely explained by the extent and nature of claimant's long-standing complaints, including her intervening/coincident overuse problems and years of pain medication. (*See id.*; Exs. 27-2; 40-3; 50A-2; 53G-1; *see also* Exs. 17; 20-29; 29A; 30-32; 33-1-4; 34-47; 51; 62A-11-16; 62A-18-20; 68A-7; 68AA; 69A; 70E; 71AA-2; 72-4; Tr. 23, 29).

We also note that *claimant* first related her ongoing problems to the 1992 fall in 1997, because she first suspected that the injury was responsible for her symptoms when Dr. Hryekewicz diagnosed a coccygeal problem (in 1997). (*See* Exs. 60A-1, 71AA). But *claimant's* failure to attribute her coccyx symptoms to the 1992 injury is not fatal (or detrimental) to her claim, because she is not charged with correctly identifying the cause of her problem. *See Weston C. Foucher*, 45 Van Natta 1617, 1618 (1993) (Causation is a question for medical experts in a medically complex case); *see also Marcella S. Lyon*, 48 Van Natta 2387, 2388 (1996) (Unrelated painful condition explained the claimant's failure to identify work injury as causative). For these reasons, as well as those set out by the ALJ, we conclude that claimant has proven her 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 is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her attorney's "Affidavit in Support of Attorney's Fee), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 24, 1998 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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[3] We note that Dr. Rosenbaum examined claimant in 1998 (the same day Dr. Bald examined her that year) and recorded a history of severe pain for at least a month, followed by improvement, then gradually increasing pain again. (Ex. 71AA-1). Dr. Rosenbaum's history is consistent with claimant's and all medical experts except Dr. Bald.

[4] The employer relies on Dr. Hryekewicz' April 7, 1997 chartnote as evidence that the effects of the 1992 injury resolved. (Ex. 52A-1). But Dr. Hryekewsicz only reported that claimant's pain decreased. (We interpret the downward-pointing arrow in the chartnote as indicating "decreasing," rather than "resolved" pain in part because of the subsequent modifier, "gradually," followed by the phrase "chronic continual," and because that interpretation is more consistent with claimant's credible testimony that her tailbone pain never ceased.)

In the Matter of the Compensation of
GAYE E. WHITEHEAD, Claimant
WCB Case No. 98-03415
ORDER ON REVIEW
Black, Chapman, Webber & Stevens, Claimant Attorneys
Norman D. Cole (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's current left knee condition. On review, the issue is whether SAIF may contest the compensability of claimant's current left knee condition.

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

In a prior order, we determined that claimant's "combined condition," consisting of preexisting degenerative changes in the left knee and a July 24, 1995 work injury, was compensable as a "new injury" claim. *Gaye E. Whitehead*, 49 Van Natta 1399 (1997). SAIF has sought judicial review of that order. (Ex. 11).

Following our 1997 order, on January 26, 1998, Dr. Woodward evaluated claimant's left knee condition at SAIF's request. Dr. Woodward concluded that, by October 20, 1995, the July 24, 1995 injury was no longer the major contributing cause of claimant's left knee condition, disability and need for treatment. (Ex. 16). Instead, according to Dr. Whitehead, the preexisting degenerative condition was the major cause of claimant's current left knee condition.

On March 2, 1998, SAIF denied claimant's current left knee condition on the ground that the July 1995 injury was not the major contributing cause of the combined left knee condition, disability and need for treatment. (Ex. 17). Claimant requested a hearing.

Two weeks later, on March 16, 1998, SAIF issued an "updated Notice of Acceptance at Closure." (Ex. 18). It listed the accepted condition as "pre-existing left knee degenerative changes." Claimant was advised that the notice was in lieu of all prior acceptances and included all conditions accepted on prior acceptance notices, "unless denied." That same day, SAIF issued a Notice of Closure awarding temporary partial disability, but stating that pre-litigation temporary and permanent disability was "stayed pending the outcome of the compensability decision." (Ex. 19).

The ALJ set aside SAIF's denial. In so doing, the ALJ found that the denial was procedurally improper under ORS 656.262(7)(b)[1] because SAIF had not accepted the claim prior to issuance of its denial. Moreover, citing *Mize v. SAIF*, 129 Or App 636 (1994), the ALJ determined that SAIF's "post-denial" acceptance of preexisting left knee degenerative changes effectively rescinded the denial.

On review, SAIF contends that its denial was procedurally proper under ORS 656.262(7)(b) and that its post-denial acceptance of claimant's degenerative changes did not rescind its denial because there was not an unequivocal acceptance of a previously denied condition. We need not address (and consequently do not adopt) that portion of the ALJ's order pertaining to the procedural propriety of SAIF's denial under ORS 656.262(7)(b).[2] Instead, we agree with the ALJ's reasoning that SAIF

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[1] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

[2] In *Tracey A. Blamires*, 50 Van Natta 1793 (1998), *on recon* 50 Van Natta 2273 (1998) we held that a "pre-closure" denial of an unaccepted combined condition was procedurally permissible when the medical evidence established that the claimant's accepted lumbar strain injury had combined with a preexisting degenerative condition and that the accepted injury was no longer the major contributing cause of the claimant's need for treatment or disability for the combined condition. In so holding, we expressly disavowed *Robin W. Spivey*, 48 Van Natta 2362 (1996) and its progeny, which had held that an acceptance of a combined condition was a prerequisite to a valid pre-closure denial under ORS 656.262(7)(b). We need not determine the applicability of *Blamires* in light of our disposition of the case.

withdrew or rescinded its prior denial when it later unequivocally accepted claimant's left knee degenerative changes. We supplement the ALJ's order as follows.

In *Mize*, before it petitioned for judicial review of a Board order, the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim and dismissed the carrier's petition for judicial review. 129 Or App 640. In so concluding, the court emphasized that, once a carrier officially notifies a claimant that it has accepted a claim, it may not subsequently deny compensability without complying with ORS 656.262(6). *Id.*

Here, two weeks after issuing its denial of claimant's current left knee condition, SAIF issued a Notice of Acceptance that unequivocally and clearly accepted claimant's left knee degenerative changes. In accordance with *Mize*, SAIF's acceptance rendered moot any controversy over the compensability of claimant's current left knee condition and effectively rescinded or withdrew its prior denial. SAIF, however, cites *Valerie Barbeau*, 49 Van Natta 1189 (1997), and *Donna J. Calhoun*, 47 Van Natta 454 (1995), in support of its argument that its acceptance of claimant's left knee degenerative changes was not unequivocal and, therefore, it can still contest the compensability of claimant's current left knee condition. We disagree.

In *Calhoun*, we held that where the employer issued a "1502" form explaining that the claim had been ordered accepted by a litigation order that was on appeal and also indicated on the Notice of Closure that it was appealing the ALJ's order, the employer's "acceptance" was not clear and unqualified and therefore not governed by ORS 656.262(6).

In *Barbeau*, the insurer issued a Notice of Acceptance. At the same time, however, it also issued a 1502 form specifically explaining that the claim was accepted through a litigation order, an order which the claimant knew the insurer had already appealed. Further, like *Calhoun*, the insurer's "pre-acceptance" Notice of Closure in *Barbeau* referenced the appeal and also stated that temporary disability compensation had been stayed. Given the insurer's explanation on the 1502 for accepting the claim when the case was on appeal and its notation on the Notice of Closure, we could not conclude in *Barbeau* that the insurer's acceptance was clear and unqualified. Rather, like *Calhoun*, we concluded that the insurer's "post-order" acceptance of claimant's claim was qualified by references in the 1502 form and the Notice of Closure and, therefore, the controversy between the parties regarding the compensability of the claim remained viable. Consequently, we denied the claimant's motion to dismiss.

In this case, SAIF alluded to its appeal of our order when it stayed compensation in its Notice of Closure pending "the outcome of the compensability decision." However, unlike *Calhoun* and *Barbeau*, SAIF did not issue a form 1502 explaining that its acceptance was conditioned on the outcome of an appeal. Instead, SAIF issued a Notice of Acceptance that clearly and unequivocally accepted claimant's preexisting degenerative changes in his left knee. While the acceptance notice stated that it included all conditions accepted on prior notices, "unless denied," we agree with the ALJ that the sentence does not apply inasmuch as there were no prior acceptances. The only condition accepted was that in the Notice of Acceptance.

In summary, we agree with the ALJ's conclusion that SAIF essentially rescinded its denial when it unequivocally accepted claimant's left knee degenerative condition. Therefore, we affirm.

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

ORDER

The ALJ's order dated August 28, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

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Cite as 328 Or 49 (1998) December 3, 1998

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Deana F. Marshall, Claimant.

DEANA F. MARSHALL, Respondent on Review,
v.
SAIF CORPORATION, Petitioner on Review.
(WCB 92-09708; CA A90412; SC S44060)

On review from the Court of Appeals.*

Argued and submitted November 4, 1997; reassigned July 16, 1998.

Michael O. Whitty, Salem, argued the cause for petitioner on review. Julene M. Quinn, Salem, filed the petition.

Meagan Flynn, of Pozzi, Wilson, Atchison, Portland, argued the cause for respondent on review.

Before Carson, Chief Justice, Gillette, Van Hoomissen, and Durham, Justices.**

GILLETTE, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

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*Judicial Review of an Order of the Workers' Compensation Board. 146 Or App 50, 931 P2d 823 (1997).

**Fadeley, J., retired January 31, 1998, and did not participate in this decision; 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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328 Or 51> In this workers' compensation case, the issue is whether claimant, a sole proprietor, submitted sufficient evidence to corroborate her claim of compensability for an occupational disease, thereby permitting recovery under ORS 656.128(3).[1]

The Workers' Compensation Board (Board) concluded that a doctor's report, based on a history provided by claimant, was insufficient and upheld the insurer's denial of the claim. The claimant appealed, and a divided Court of Appeals, sitting *en banc*, reversed, holding that a doctor's opinion as to diagnosis, causation, and treatment is, by its very nature, based on more than a patient's statements and, therefore, corroborates the components of proof of compensability. *Marshall v. SAIF Corp.*, 146 Or App 50, 931 P2d 823 (1997) (*Marshall II*). We allowed the insurer's petition for review to consider the quantity and quality of corroborative evidence that must appear in the record to satisfy the requirements of ORS 656.128(3). We now affirm the decision of the Court of Appeals, but on different grounds.

The facts of the case that are pertinent to the issue before the court are undisputed. Claimant has been a hairdresser for 35 years. For approximately the past 20 years, she has been the sole proprietor of her own salon. She elected workers' compensation coverage for herself with SAIF Corporation (SAIF) under ORS 656.128.

In 1991, claimant began to notice pain in her right hand and arm. The symptoms gradually worsened and, by January 1992, the pain had radiated up through her wrist and elbow into her shoulder. In February 1992, claimant consulted a physician, Dr. Rabie, who diagnosed tendinitis and capsulitis in her right index finger, thumb, elbow, and shoulder. Based on claimant's account of her condition, Rabie concluded that the problem was the result of her repetitious hand and arm movements at work, and instructed her to limit her work to four hours per day.

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[1] ORS 656.128(3) provides:

"No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant."

328 Or 52> In April 1992, claimant submitted a workers' compensation claim for tendinitis in her right thumb, finger, elbow, and shoulder. SAIF denied the claim on the ground that claimant's work as a hairdresser was not the major contributing cause of the development or worsening of her tendinitis. Claimant requested a hearing and, before a Hearings Division referee, presented her own testimony as to compensability, along with Rabie's report diagnosing tendinitis and concluding, based on information that claimant had provided to him, that claimant's condition resulted from her work activities.

After the hearing, SAIF submitted a trial memorandum to the referee in which it contended that, in addition to its other reasons for denying claimant's claim, the claim should be denied because claimant failed to sustain her burden of proof as a sole proprietor under ORS 656.128(3).[2] SAIF argued that, because the only evidence that claimant offered at the hearing to support the claim that the condition was work-related was claimant's own testimony and the doctor's report (which, itself, was based on claimant's own recitation of her history), claimant had failed to submit corroborative evidence "in addition to" her own evidence.

In response, claimant argued, among other things, that ORS 656.128(3) requires sole proprietors to submit evidence corroborating only the fact of coverage under the workers' compensation statute (which is not in dispute in this case), not compensability under that law. The referee accepted that interpretation and concluded that claimant had proved that she was eligible for workers' compensation coverage as a self-employed worker. Turning to the merits of claimant's claim, the referee found that claimant's work required fast, repetitive use of her hands and arms, that she performed no repetitive activities with her hands off-work, and that claimant's work activity as a hairdresser was the major contributing cause of her condition. He concluded that claimant had met her burden of proof. SAIF requested review. The Board affirmed and adopted the referee's order.

328 Or 53> SAIF sought judicial review in the Court of Appeals. That court reversed the Board on the issue of the proper interpretation of ORS 656.128(3), holding that "the corroboration requirement pertains to facts essential to the allowance or payment of claims for compensation, *i.e.*, compensability," rather than to coverage. *SAIF Corp. v. Marshall*, 130 Or App 507, 510, 882 P2d 1115, *rev den* 320 Or 492, 887 P2d 793 (1994) (*Marshall I*). It remanded the case to the Board for reconsideration.

On remand, claimant asserted that her consistent medical histories, provided to her own doctor and to the physicians who examined her on behalf of SAIF, as well as her consistent statement to SAIF's investigator, constituted sufficient corroborative evidence to satisfy the requirements of ORS 656.128(3).[3]

In its order on remand, the Board held that the corroborative evidence required by the statute "must be supplementary to and of a different character from claimant's evidence." On the facts of the present case, the Board concluded that neither the physicians' reports nor claimant's statement to the investigator constituted "corroborative evidence in addition to the evidence of the claimant," inasmuch as they were not supplementary to or different in character from her own testimony. According to the Board, the medical reports corroborated the existence of claimant's medical *condition*, but they did not corroborate the *cause* of that condition. Consequently, it reinstated and upheld SAIF's denial of claimant's claim.[4]

Claimant again sought judicial review in the Court of Appeals, this time assigning error to the Board's conclusion that Rabie's medical report did not constitute corroborative evidence of compensability and, alternatively, to the Board's refusal to remand the case to the referee to allow claimant to present additional corroborative evidence. The <328 Or 53/54> Court of Appeals reversed the Board on the first issue and, therefore, did not reach the second.

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[2] SAIF also had raised the general issue of the applicability of ORS 656.128(3) orally at the hearing.

[3] Claimant also asked the Board to remand the case to the referee for the presentation of additional corroborative evidence, should the Board find her corroboration argument unpersuasive.

[4] The Board refused to remand the case to the referee to allow claimant to offer additional evidence.

In its opinion, the Court of Appeals began by analyzing the wording of ORS 656.128(3), using the methodology prescribed by this court in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). It looked at the text of the statute and construed words of common usage according to their plain, natural, and ordinary meaning. *Marshall II*, 146 Or App at 53. The court noted that the word "corroborative" is not defined in the statute but that, according to *Webster's Third New World Dictionary*, 512 (1971), "corroborative" means "tending to make more certain." *Marshall II*, 146 Or App at 53. The court also noted that *Black's Law Dictionary*, 414 (rev 4th ed 1968) defines "corroborating evidence" as "[e]vidence supplementary to that already given and tending to strengthen or confirm it; additional evidence of a different character to the same point." Based on those dictionary definitions, the court concluded that "any evidence that makes more certain *either* the 'arising out of' or 'in the course of' prong of compensability is corroborative." *Id.* at 53-54 (emphasis in original).[5]

The Court of Appeals assumed, for the sake of discussion, that the phrase "evidence of the claimant" in ORS 656.128(3) means claimant's own statements and then rejected SAIF's argument that the medical reports are not in *addition* to claimant's statements. *Id.* at 54. The court stated that, although the doctor relied on the patient's history to formulate a medical opinion, the opinion was his own, based collectively on the patient's history, a physical examination, and the doctor's own expertise. *Ibid.* The court held that,

> "[n]ot only are the medical reports 'in addition to' claimant's statements, they do, in fact, corroborate compensability. They show that the claimant described to her doctor the same employment conditions that she had reported on her **<328 Or 54/55>** claim and to which she testified. The doctor's opinion attributes claimant's injury and need for treatment to the employment conditions claimant described. The reports accordingly corroborate both the 'arising out of' and 'in the course of' components of proof of compensability, ORS 656.005(7), and satisfy the requirement of ORS 656.128(3), because they make more certain the compensability of the claim."

Ibid.

On review, we need not address the correctness of the Court of Appeals' reasoning regarding the sufficiency of the medical reports, because, for the following reasons, we conclude that sufficient corroborative evidence is present in this case to support the claim.

At the outset, we note that claimant's tendinitis is compensable, if at all, as an "occupational disease" under ORS 656.802(1)(a)(C). That section defines an occupational disease as a "series of traumatic events or occurrences which requires medical services or results in physical disability," that "arise[s] 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." Employment conditions must be "the major contributing cause of the disease." ORS 656.802(2)(a).

Claimant has the burden of proving, by a preponderance of the evidence, that the occupational disease is compensable. ORS 656.266; *Hutcheson v. Weyerhaeuser*, 288 Or 51, 55-56, 602 P2d 268 (1979). In the ordinary case, where the claimant is an employee of a covered employer, the claimant can make out a *prima facie* case of compensability with her own testimony, so long as it is credible, together with "medical evidence supported by objective findings" establishing the existence of an occupational disease. ORS 656.802(2)(d). Where, as here, the claimant is a sole proprietor, however, she carries an additional burden. ORS 656.128(3) provides:

> "[n]o claim shall be allowed or paid under this section [permitting sole proprietors to elect workers' compensation coverage], except upon corroborative evidence in addition to the evidence of the claimant."

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[5] Although not discussed in the Court of Appeals' opinion, the reference to the "'arising out of' or 'in the course of' prong" is a reference to the workers' compensation statute that defines a compensable injury or occupational disease as one "arising out of and in the course of employment." ORS 656.005(7)(a); ORS 656.802(1)(a). *See, e.g., Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526, 919 P2d 465 (1996) (explaining that the "arising out of" and "in the course of" requirements of the statute are two parts, or "prongs," of a single, unitary, test).

328 Or 56> The statute requires the claimant to produce corroborative evidence in addition to the "*evidence* of the claimant." (Emphasis added.) However, as the Court of Appeals recognized, the statute does not define the phrases "corroborative evidence" or "evidence of the claimant," nor does it specify what, exactly, must be corroborated. As did the Court of Appeals, we attempt to discern the intent of the legislature using the methodology set out in *PGE v. Bureau of Labor and Industries*, 317 Or at 610-612. At the first level of our analysis, we look at the text and context of the statutory section itself. *Id.* at 610-611.

It is clear that the legislature could not have intended the phrase "evidence of the claimant" to mean all the evidence a claimant presents at a workers' compensation hearing, for that would lead to the absurd result that no claimant could ever meet the burden because any evidence offered as corroboration would, itself, be "evidence of the claimant." At the same time, the statute does not require merely that a claimant's *testimony* be corroborated by other evidence. The text, therefore, suggests that something more is required and appears to reflect a heightened legislative concern over a claimant's credibility. It is evident from the wording in ORS 656.128(3), that the purpose of the statute is to prevent fraud; that is, to prevent a sole proprietor from falsely claiming workers' compensation coverage for any injury or occupational disease that is not compensable. We conclude, therefore, that it is a claimant's statements, in or outside of a legal proceeding, that must be corroborated under ORS 656.128(3).

Turning to "corroborative evidence," we agree with the Court of Appeals' definition of that phrase, as "evidence, different from the evidence of the claimant, that tends to make more certain the compensability of the claim." *Marshall II*, 146 Or App at 53. We have defined corroboration or corroborative evidence similarly in other contexts in our decisions over the years. For example, in *Farmers Insurance Exch. v. Colton*, 264 Or 210, 217, 504 P2d 1041 (1972), quoting 2 E. Conrad, Modern Trial Evidence section 1155 (1956), we held that "corroboration" is "'something which leads an <328 Or 56/57> impartial and reasonable mind to believe that material testimony is true, testimony of some substantial fact or circumstance independent of a statement of a witness.'" Nothing in the statutory context of ORS 656.128(3) points to a different interpretation. Therefore, we hold that the corroborative evidence required in ORS 656.128(3) must be independent of and apart from claimant's own statements.

The remaining question, then, is what, exactly, a sole proprietor must corroborate. As the Court of Appeals held in *Marshall I*, the wording of the statute requires the claimant to corroborate *compensability*. To be compensable, an injury or occupational disease must arise out of and in the course of employment. ORS 656.005(7)(a); ORS 656.802(1)(a). In the case of an occupational disease, there is the additional requirement that the employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). We have held, in the context of an accidental injury, that the "arising out of" prong and the "in the course of" prong are "two parts of a single 'work-connection' analysis, in order to determine whether an employee suffered a compensable injury." *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526, 919 P2d 465 (1996); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366, 867 P2d 1373 (1994) ("'arising out of' and 'in the course of' are two elements of a single inquiry"). Likewise, the requirement that employment conditions be the major contributing cause of an occupational disease is part of that "work-connection" analysis.

To corroborate *compensability*, then, a sole proprietor must provide not only corroborative evidence of the existence of the injury or disease, but also corroborative evidence that the injury or occupational disease is *work-related*. The evidence is "*corroborative*" if it supplements, strengthens, and confirms the testimony of the claimant and tends to verify her version of the facts. Nothing in ORS 656.128(3), however, requires the claimant establish a *prima facie* case with corroborative evidence. We hold that a sole proprietor satisfies the corroboration requirement of ORS 656.128(3) if she provides *any* evidence, independent of and apart from her own statements, that supplements, strengthens, and confirms that the injury or disease exists and that it is work-related. We thus find the statute's meaning to be clear at the <328 Or 57/58> first level of inquiry, and need not inquire further. *PGE v. Bureau of Labor and Industries*, 317 Or at 611.

At the hearing before the Board, claimant provided corroborative evidence of the *existence* of her tendinitis in the form of Rabie's medical report. It is true that even the doctor's medical conclusions are based, in part, on claimant's complaints of pain in her hand, arm, and shoulder. Yet, the doctor's own examination, expertise, and diagnosis are necessary to confirm that the disease of tendinitis exists. That additional "evidence" provides sufficient corroboration of claimant's claim in that regard.

Finally, we consider whether the doctor's report corroborated claimant's assertion that the tendinitis is work-related. We hold that it did, under the peculiar facts presented here. There are a few kinds of employment that are so familiar to the ordinary person that no further proof of specific physical activities by a claimant on the job is required. We believe that the work of a hairdresser fits within such a class. Most persons have observed hairdressing first hand and, even for those who have not, they almost surely are aware that the work requires rapid and repetitious hand and arm movements. The doctor should be deemed to have been aware of that fact independent of claimant's history. Thus, in this case, the necessary corroboration was present.

SAIF argues that claimant separately must corroborate the fact that her work was the major contributing cause of her disease. The effect of that argument in the present case would be to require claimant to submit corroborative evidence of a negative, *viz.*, of the fact that she did not carry on activities off the job that involved rapid and repetitious hand and arm movements of the kind that could have caused her tendinitis. We hold, however, that claimant satisfied that requirement of ORS 656.128(3) by providing evidence corroborating the job-related nature of her claim. That, coupled with her denial of similar physical activity off the job, made out her *prima facie* case.

It follows from the foregoing that, although we disagree with portions of the analysis of the Court of Appeals in this case, we do agree with its conclusion.

328 Or 59> The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 156 Or App 75 (1998) September 9, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ESTATE OF LINDA GREENSLITT
by and through the co-personal representatives of her estate,
ROBIN L. CANTU and BRETT A. GREENSLITT, Appellants,
v.
FARMERS INSURANCE COMPANY OF OREGON, an Oregon corporation, Respondent,
and CLETUS DONALD KIRSCH, SR. and TIMOTHY EARL CORZINE, Defendants.
(9602-01046; CA A95592)

Appeal from Circuit Court, Multnomah County.
Marshall L. Amiton, Judge.
Argued and submitted February 25, 1998.
Meagan A. Flynn argued the cause for appellants. With her on the briefs were Pozzi Wilson Atchison, LLP.
John S. Cavanagh argued the cause for respondent. With him on the brief was Cavanagh & Zipse.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Affirmed.

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156 Or App 77> Plaintiffs appeal a judgment denying their claim for payment of underinsured motorist (UIM) benefits. The insurance policy at issue was maintained by plaintiffs' mother, Linda Greenslitt (decedent), who was killed in a work-related automobile accident. Her death resulted in payment of workers' compensation benefits, including death benefits to two dependents (a granddaughter and a great-granddaughter). Plaintiffs, because of their adult status, were not eligible for death benefits under the workers' compensation scheme. The trial court determined that the amount of UIM benefits to be paid to the decedent's wrongful death estate, and thus to her grown children, should be offset by the full amount of workers' compensation benefits paid and payable to the granddaughter and great-granddaughter. The question on appeal is whether the trial court correctly understood ORS 742.504(7)(c)(B) to require that offset.

The parties stipulated to the relevant facts. Decedent, while acting in the course and scope of her employment, was killed on August 30, 1994, in an automobile accident caused by the negligence of two individuals, Cletus Donald Kirsch, Sr., and Timothy Earl Corzine. Decedent was survived by her husband, son, daughter, mother, granddaughter, and great-granddaughter. At the time of her death, decedent's granddaughter and great-granddaughter lived with her and were her legal dependents.

Pursuant to the payment priorities set out in ORS 656.204, workers' compensation insurance paid some of the expenses arising from the accident (*i.e.*, medical, ambulance, burial and memorial services). It also paid death benefits to decedent's husband, until his own death a few months after decedent's. Additionally, because of their status as dependents, decedent's granddaughter and great-granddaughter were eligible for death benefits. ORS 656.204(5)(a). The granddaughter received benefits for about one year, until she turned 19 years old. Decedent's great-granddaughter, who was born in 1993, qualified for benefits of $400 per month and will receive those benefits at least until she turns 19 years old. ORS 656.204(5)(a) and (8)(a) (benefits payable to **<156 Or App 77/78>** dependent until age 19 years, unless dependant attends higher education program).

The two tortfeasors each maintained a policy of automobile liability insurance with a limit of $25,000 per claim. The estate "settled" the claims against the tortfeasors for $50,000, the total available liability insurance. Under decedent's automobile insurance policy, she had UIM coverage of $100,000 per person for injuries and death caused by underinsured motorists. Thus, absent any other offsets, the insurance company would owe the estate $50,000 in UIM benefits, which is the difference between the total amount of UIM coverage ($100,000) and the amount recovered under the tortfeasor's liability policy ($50,000). ORS 742.502(2)(a). However, defendant (Farmer's Insurance Company) denied the estate's claim for UIM benefits, contending that it is entitled under ORS 742.504(7)(c)(B) to offset the workers' compensation benefits paid and payable in the future against the UIM amount otherwise due. There is no dispute that the present value of the benefits to be paid to the great-granddaughter, together with

the other benefits already paid, exceed defendant's total possible UIM liability. Consequently, defendant took the position that it had no UIM liability to the wrongful death estate and denied the UIM claim.

Plaintiffs, as personal representatives of decedent's estate, brought this action, contending that the offset was improper and that defendant therefore had not satisfied its UIM obligation.[1] The trial court agreed with defendant that ORS 742.504(7)(c)(B) requires the workers' compensation benefits payable to decedent's granddaughter and great-granddaughter to be offset against any UIM benefits owed to decedent's estate. Because the amount of those benefits **<156 Or App 78/79>** exceed the potential UIM obligation, the trial court granted summary judgment for defendant, determining that defendant owed nothing to plaintiffs.

The issue on appeal is whether the offset under ORS 742.504(7)(c)(B) was proper. That issue arises because, under these particular facts, benefits under the workers' compensation law flow to different beneficiaries than would UIM benefits. Under the wrongful death statute, decedent's granddaughter and great-granddaughter are not "heirs" who are entitled to recover any part of the decedent's estate. Thus, despite their status as dependents, no portion of the UIM benefits that are payable to the estate would be distributed to them.[2] *See generally Liberty Northwest Ins. Corp. v. Golden*, 116 Or App 64, 67, 840 P2d 1362 (1992) ("[B]eneficiaries of a wrongful death action, ORS 30.020, are not the same as beneficiaries under the Workers' Compensation Act"). Plaintiffs argue that the offset should not apply where, as here, workers' compensation benefits were payable to persons other than those who are entitled to receive the UIM benefits. Essentially, plaintiffs claim that the legislature intended to limit offsets only so as to prevent a "double recovery" by the same party. Because decedent's granddaughter and great-granddaughter are not entitled to the UIM benefits, there would be no double recovery in this case. Defendant responds that the language of the statute requires the offset in all cases, without distinguishing circumstances in which the beneficiaries of the workers' compensation insurance and the beneficiaries of the wrongful death estate are not the same.

The starting point for construing the statute is, of course, its text. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). ORS 742.504(7)(c)(B) states:

> "(c) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by:
>
> **156 Or App 80>** "* * * * *
>
> "(B) The amount paid and the present value of all amounts payable on account of such bodily injury under any workers' compensation law, disability benefits law or any similar law."[3]

The express language provides, without limit or exception, that UIM benefits for a particular bodily injury are to be reduced by the amount paid and the present value of "all amounts payable" on account of that same bodily injury under any workers' compensation, disability, or similar law.[4] The words of

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[1] On appeal, as below, there is also an issue regarding a workers' compensation lien of $13,500 that was paid from the $50,000 tortfeasor settlement, pursuant to ORS 656.593(1). Although plaintiffs do not dispute the propriety of paying the lien from the settlement, they do argue that the recovery from the tortfeasors should be calculated as only $36,500 instead of $50,000. The UIM obligation then would be $63,500, assuming no other offsets or reductions. Plaintiffs agree that the issue is academic and need not be decided if the offset for other workers' compensation benefits is proper, because that offset exceeds the amount of available UIM benefits, no matter how the $13,500 lien is treated. Because we conclude that the offset for workers' compensation benefits was statutorily required, we do no reach plaintiffs' assignment of error regarding the lien calculation.

[2] Although by its terms ORS 742.504 relates only to "uninsured" motorist coverage, it extends equally to "underinsured" motorist coverage by virtue of the cross-reference contained in ORS 742.502(4).

[3] Virtually the same language appears in decedent's insurance policy.

[4] The fact that the statute refers not just to Oregon's Workers' Compensation Act, but to *any* disability, workers' compensation, or similar law, bolsters the analysis. The legislature could not have expected parity between who qualifies as beneficiaries under the laws of other jurisdictions and who qualify as beneficiaries under Oregon's wrongful death statute.

the statute are straightforward and clear. By referring to "all amounts payable" without qualification or exception, we must assume that the statute means "all" amounts payable, nothing more and nothing less. There is no wiggle room for differing interpretations, nor ambiguity that creates uncertainty.

Nevertheless, plaintiffs suggest that when the language above is read in the context of other provisions relating to UIM benefits, a contrary understanding of the statute emerges. Specifically, plaintiffs point to ORS 742.502(2)(a), which provides that underinsurance benefits shall be equal to uninsured motorist coverage benefits "less the amount recovered from other automobile liability insurance policies." Plaintiffs place particular emphasis on the term "recovered." Their argument appears to be that because the statute refers to amounts "recovered" from the tortfeasor's liability insurer, the statute reflects a policy of reducing the UIM benefit based only on the amount that actually ends up in the hands of the UIM beneficiary; thus, an offset based on amounts paid or payable to persons other than the UIM beneficiary was not the legislature's intent.

ORS 742.502 simply will not bear the weight of plaintiffs' argument. That statute does one thing, and one thing only: it explains how to calculate the offset for liability **<156 Or App 80/81>** payments from the tortfeasor's insurer. In doing so, it provides a baseline formula: UIM benefits equal the amount of coverage for uninsured motorists (here, $100,000), less the amount of any liability recovery from other insurers (here, $50,000[5].) Whether other amounts should be offset from the amount of UIM coverage is determined by other statutes, reflecting other legislative policy choices. The provision for an offset for *all* workers' compensation benefits paid and payable on account of the injury is one such policy (ORS 742.504(7)(c)(B)), as is the provision for a lien for other expenses incurred by the workers' compensation insurer (ORS 656.593(1)). In short, given that the statutes address different offsets, ORS 742.502 is not context that requires us, or even permits us, to refuse to give effect to the plain language of ORS 742.504.[6]

Plaintiffs also emphasize the inherent unfairness of the offset being applied to reduce UIM coverage for estate beneficiaries who did not receive workers' compensation benefits. They point to the fact that the offset defeats the overall goal of UIM coverage, which is to place the injured party in the same position as if the tortfeasor had full liability insurance. An insured made a similar argument in *California Casualty Indemnity Exchange v. Maritzen*, 123 Or App 166, 172, 860 P2d 259 (1993), urging that workers' compensation benefits should never be offset against UIM coverage, even where the beneficiaries are the same, because the offset defeats the goal of UIM coverage. The express and unequivocal terms of ORS 742.504(7)(c) precluded us from declining to make the offset, however. *Id.* The same is true here. Plaintiffs' policy arguments properly must be directed to the legislature.[7]

Finally, plaintiffs urge us to overrule *Maritzen*, which holds that an offset from uninsured motorist benefits is taken against the policy limits rather than against the total damages payable by a tortfeasor. We decline to reexamine our holding in that case.

Affirmed.

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[5] Again, we note that because the $13,500 workers' compensation lien was paid from the $50,000 settlement from the tortfeasors insurers, plaintiffs dispute whether the amount "recovered" should be deemed $36,500 or $50,000. For purposes of the illustration, we use the full amount paid by the tortfeasors' insurers.

[6] We reject, without elaboration, plaintiffs' further argument that survivor benefits paid to decedent's dependents somehow are not for the same bodily injury as the UIM benefits payable to the estate, and thus should not be deemed to be payments for "such bodily injury" with the meaning of ORS 742.504(7)(c)(B). The linguistic acrobatics required to read the statute in that way defy common sense and *PGE* alike.

[7] Plaintiffs also raise a constitutional challenge to the offset under the Article I, section 10, Remedy Clause. Their brief does not demonstrate that the argument was raised below, nor does our review of the record reveal that the issue was preserved. We decline to consider the issue. ORAP 5.45(2).

Cite as 156 Or App 168 (1998) September 30, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Peter Gevers, Claimant.

PETER GEVERS, Petitioner,
v.
ROADRUNNER CONSTRUCTION and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(WCB No. 95-10971; CA A99032)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 3, 1998.
Robert Pardington argued the cause for petitioner. On the brief were Richard S. Springer and Pozzi Wilson Atchison.
Alexander D. Libmann argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge pro tempore, and Edmonds and Landau, Judges.
RIGGS, P. J. *pro tempore.*
Reversed and remanded.

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156 Or App 170> Claimant challenges an order of the Workers' Compensation Board (the board) denying his request for additional unscheduled permanent partial disability (PPD) for aggravation of his existing shoulder condition. We review for errors of law and substantial evidence, ORS 656.298(7); ORS 183.482(7) and (8), and reverse and remand.

We summarize the relevant facts from the board's order. Claimant suffered compensable injuries to both shoulders in a 1988 fall from a scaffold. Following multiple surgeries, claimant was declared medically stationary in 1990. A 1992 determination order awarded him 74 percent unscheduled PPD for his shoulders and 19 percent scheduled PPD for damage to his left arm.

In December 1992, insurer accepted a claim for aggravation of claimant's left shoulder condition. Claimant had two additional surgeries on that shoulder and again was declared medically stationary in November 1994. A determination award, issued in April 1995, awarded claimant temporary disability but no additional PPD for his left shoulder.

Claimant requested reconsideration and examination by a medical arbiter panel, as provided in ORS 656.268(7)(b). The panel issued the report of its examination of claimant on September 8, 1995. The panel found that claimant displayed "a marked decreased ability to repetitively use the left shoulder"[1] and further noted that claimant had suffered a significant loss of strength in his left shoulder. The report states: "The decreased strength is due to perijoint fibrosis and not to any one specific nerve muscle or tendon unit."[2]

156 Or App 171> Based upon that report, the department issued an order on reconsideration affirming the determination order. Claimant requested a hearing, and, on February 20, 1996, an administrative law judge (ALJ) issued an order affirming the order on reconsideration. Claimant appealed the ALJ's order to the board, and on August 1, 1997, the board issued an order on review affirming that order.

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[1] The board's order on appeal in this case erroneously reports the panel's finding concerning repetitive use of the left shoulder as "a marked *increase* in [claimant's] ability to repetitively use his left shoulder." (Emphasis added.) Because we reverse the board's decision on other grounds, we need not decide the effect, if any, of that error.

[2] We note that there is a discrepancy between the copy of the medical arbiter's report that was designated as an exhibit and the copies of the report that appear in the parties' briefs. The latter contains an additional sentence after the language quoted above. That sentence, which does not appear in the exhibit copy, reads, "There is atrophy of the infra and supraspinatus muscles and probable disruption of the rotator cuff." The parties do not draw our attention to the discrepancy, nor is it central to their arguments. Because it is not part of the copy of the medical arbiter's report in the record, we decline to consider the impact, if any, of the additional text. We note, however, that it does not appear to contradict our analysis or conclusion in this case.

In rejecting claimant's request for additional PPD, the board focused on the medical arbiters' finding that claimant's loss of shoulder strength "was not due to any one specific nerve muscle or tendon unit." While acknowledging claimant's "decreased strength" and "increase in impairment," the board concluded that claimant's inability to attribute his loss of strength to damage to a particular nerve made his condition unratable. The board's order on review states, in pertinent part:

> "[W]e are unwilling to infer an injury to each named peripheral nerve * * * (or to any specific peripheral nerve that innervates the muscles of the left shoulder) in the absence of supporting medical evidence. * * * Here, the record establishes only that claimant's decreased strength is due to 'perijoint fibrosis.' We cannot logically infer from the arbiters' report any injury to a specific named peripheral nerve or any injury to a specific nerve muscle or tendon unit. Consequently, we conclude that claimant's decreased left shoulder strength is not ratable under the applicable standards."

Claimant argued to the ALJ and to the board that his condition was ratable under either of the two board rules addressing loss of shoulder strength that were in effect at the time, *former* OAR 436-35-350(3) and (5) (1993).[3] As noted **<156 Or App 171/172>** above, the board's order contains a finding that claimant has not suffered damage to a specific shoulder nerve. On review, claimant does not assign error to that finding, although subsection (3) requires a showing of injury to a "specific named nerve." However, he contends that the board erred in rejecting his claim under *former* OAR 436-35-350(5), because, in his view, that subsection allows recovery even absent a showing of damage to a specific nerve.

Claimant argues that the board incorrectly addressed his claim under subsection (5) together with his claim under subsection (3) and erroneously rejected *both* on the ground that he had failed to prove damage to a particular nerve. Respondents counter that the board's ruling was correct because subsection (5), like subsection (3), requires proof of nerve damage.

We agree with claimant that *former* OAR 436-35-350(5) does not require a showing of nerve damage for a loss of shoulder strength to be ratable.[4] In interpreting administrative rules, we apply the same rules that apply to the construction of statutes. *Perlenfein and Perlenfein*, 316 Or 16, 20, 848 P2d 604 (1993); *Liberty Northwest Ins. Corp. v. Jensen*, 150 Or App 548, 552, 946 P2d 689 (1997). Our first level of inquiry into the meaning of statutes and rules is examination of text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). Here, the text of subsection (5) makes no mention of damage to specific nerves. Rather, the subsection refers to "loss of strength due to muscle loss or damage to the musculotendinous unit" and states that such loss is to be rated "*as if* the nerve supplying that muscle or muscle group were impaired." (Emphasis added.) Rating loss of strength due to muscle loss *as if* a nerve **<156 Or App 172/173>** were damaged demonstrates that subsection (5) was intended to apply in cases where the nerve is not *in fact* damaged. The text of the rule unambiguously refers to muscle and tendon-related losses of strength and offers no support for respondents' contention that claimant must show damage to a specific nerve for his condition to be ratable under subsection (5).

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[3] *Former* OAR 436-35-330(19) (1993) provided:

> "For injuries resulting in loss of strength of the shoulder refer to OAR 436-35-350(3) and (5)."

Former OAR 436-35-350(3) provided, in part:

> "Injuries to a unilateral specific named peripheral nerve with resultant loss of strength shall be determined based upon a preponderance of medical opinion that reports loss of strength * * * and establishes which specific named peripheral nerve is involved."

Former OAR 436-35-350(5) provided:

> "Loss of strength due to muscle loss or disruption of the musculotendinous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired."

[4] We owe no deference to the board's interpretation of the rule, because "[w]e apply that deferential standard only when the body interpreting the rule also is the body that promulgated it." *Dunning v. Corrections Facility Siting Authority*, 325 Or 269, 277 n 4, 935 P2d 1209 (1997); *see also Safeway Stores, Inc. v. Cornell*, 148 Or App 107, 111, 939 P2d 99 (1997). The department, not the board, promulgated *former* OAR 436-35-350(5).

Statutory context also supports claimant's reading of subsection (5). Our inquiry into context includes review of related rules or statutes. *PGE*, 317 Or at 611. Here, we need look no farther than *former* OAR 436-35-350(3) to find support for claimant's position. That subsection specifically refers to claims arising from "injuries to a unilateral specific named nerve with resultant loss of strength." Taken together with subsection (5), that rule establishes a framework for analyzing loss of shoulder strength: Losses related to nerve injury are rated under subsection (3), while losses related to muscle loss or disruption of a musculotendinous unit are rated under subsection (5). Respondents' contention that subsection (5) requires a showing of damage to a specific nerve would turn that subsection into a virtual duplicate of subsection (3). Respondents have identified no factual situation in which subsection (5) would have independent effect under their reading, and we can think of none.

The text and context of *former* OAR 436-35-350(5) demonstrate that a claimant need not show damage to a particular nerve for loss of shoulder strength to be ratable. The board appears to have rejected claimant's request for additional PPD under subsection (5) on the basis of his failure to show such damage, and, accordingly, the board erred.[5] We **<156 Or App 173/174>** remand to the board with instructions to consider whether claimant's decrease in shoulder strength is due to "muscle loss or disruption of the musculotendinous unit" and, if so, to value the loss of strength under *former* OAR 436-35-350(5).

Further, if the board determines that claimant's loss of strength is *not* ratable under that subsection, then ORS 656.726(3)(f)(C) requires the board to remand the case to the director for adoption of a temporary rule under which to assess claimant's increased disability. ORS 656.726(3)(f)(C) provides, in part:

> "When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, *the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.*" (Emphasis added.)

Both the ALJ and the board appear to have been under the impression that ORS 656.726(3)(f)(C) requires a claimant to request adoption of a temporary rule; the board's order, for example, states "[a]s the ALJ noted, the record does not indicate that claimant requested the adoption of a temporary rule addressing loss of strength attributable to formation of fibrous tissues."

Claimant is not required to request a temporary rule under the circumstances outlined in ORS 656.726(3)(f)(C). As we previously have stated, that statute unambiguously requires the director to adopt a temporary rule in cases where "it is found" that the claimant's disability is not addressed in the standards, and the board has implicit authority to remand a case to the director for the adoption of such a rule. *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 541, 863 P2d 530 (1993). The requirement that the director "shall" adopt such a rule makes clear that the rulemaking process is not undertaken at the director's discretion. *Id.*; *see also Shubert v. Blue Chips*, 151 Or App 710, 714, 951 P2d 172 (1997); *Simon v. PIE Nationwide, Inc.*, 142 Or App **<156 Or App 174/175>** 411, 416, 921 P2d 421 (1996). Nothing in the statute suggests that the director may stay the mandatory process of promulgating a temporary rule until a claimant requests it, or avoid the process altogether if the claimant never does so. Mindful of our mandate "not to insert what has been omitted" when construing statutes, ORS 174.010, we decline to read into ORS 656.726(3)(f)(C) the requirement that a claimant must request a temporary rule to trigger the director's duty to adopt such a rule.

Reversed and remanded.

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[5] The board's order does state that the board "cannot logically infer from the arbiters' report any injury to a named specific peripheral nerve or any *injury to a specific nerve muscle or tendon unit.*" (Emphasis added.) It might be argued that the quoted passage demonstrates that the board in fact considered and rejected claimant's contention that his loss of strength was due to muscle or tendon damage, without requiring a connection to specified nerve. The report refers to the lack of evidence of "injury" to muscle; however, *former* OAR 436-35-350(5) does not require a showing of such injury but, rather, a showing of "muscle loss." Accordingly, we are left to conclude that the board rejected claimant's request under the mistaken belief that *former* subsection (5) required a showing of injury to a specific nerve or nerve-muscle unit. Our conclusion is bolstered by the fact that the board was affirming the ALJ's hearing order, which unambiguously applied the requirement of nerve injury to claimant's request under both subsection (3) and subsection (5), stating "[t]he arbiter's finding of loss of strength is based not upon a named spinal nerve root, peripheral nerve or plexus * * *."

Cite as 156 Or App 411 (1998) October 7, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

U.S. WEST PROPERTIES, INC., an Oregon corporation, Respondent,
v.
AOI COMPWISE WORKER'S COMPENSATION PROGRAM
and JBL&K MARKETING, INC., an Oregon corporation, Respondent,
and SAIF CORPORATION, an Oregon corporation, Appellant.
(9411-07939; CA A93628)

Appeal from Circuit Court, Multnomah County.
Stephen L. Gallagher, Judge.
Argued and submitted January 6, 1998.
John T. Bagg, Assistant Attorney General, argued the cause for appellant. With him on the opening brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Montgomery W. Cobb argued the cause for respondent U.S. West Properties, Inc. With him on the brief was Cobb and Woodworth, LLP.
Paul Duden argued the cause for respondent AOI Compwise. With him on the brief were Michael J. Gentry and Tooze Duden Creamer Frank & Hutchison.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Reversed and remanded.
Armstrong, J., dissenting.

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156 Or App 411> In this action for breach of an insurance contract for failing to maintain plaintiff's workers' compensation insurance in effect and for declaratory relief, SAIF appeals from a judgment by the trial court that plaintiff's workers' compensation insurance policy was not effectively canceled. SAIF argues that the trial court erred in finding that the policy remained in force in light of a notice of cancellation that it mailed. We reverse.

Plaintiff is an employer subject to the Oregon Workers' Compensation Law. ORS 656.023. AOI is a workers' compensation marketing entity, underwritten by SAIF and administered by JBL&K Marketing, Inc. In May 1992, plaintiff obtained a workers' compensation insurance policy through AOI. The policy was for a one-year period. With regard to cancellation, the policy provides:

> "2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice."

In addition, the insurance policy folder that was furnished to plaintiff included a "Business Change Form." The information on the front cover of the folder instructed plaintiff to send the Business Change Form to AOI in the event that plaintiff added a new location. The location of plaintiff's business was listed on Item 1 of the Information Page as SE 31st Street, Milwaukie, Oregon.

In September 1992, plaintiff changed the location of its business. Its president sent a change of address card to the post office, but it did not report the change of location to AOI. In December 1992, plaintiff's president telephoned AOI. He asked general questions about the policy, payments due and requirements regarding payroll reports. He mentioned that plaintiff had changed its location and that he would be sending in the address of the new location along with his next premium payment. AOI received a premium payment on December 11, 1992, but has no record that it received a change of **<156 Or App 413/414>** address notification with the payment. Premium checks are routed to and handled by AOI's accounting department.

The next contact that plaintiff had with AOI was on February 24, 1993, when its president talked with another representative of AOI. According to that representative, no mention was made of the

change in location of plaintiff's business. In March 1993, plaintiff renewed its policy by paying an annual premium. In early May 1993, AOI sent forms for payroll reports to plaintiff. Under the policy, plaintiff was obligated to complete and return the reports. The reports were mailed to the SE 31st Street address in Milwaukie. The post office returned the mailing as undeliverable. On May 17, 1993, AOI made a follow-up telephone call to the only telephone number that it had for plaintiff and learned that the telephone number had been disconnected. Shortly thereafter, AOI mailed a letter to plaintiff notifying it that the payroll reports had not been completed and returned. That letter was also returned as undeliverable. A representative of AOI made another follow-up telephone call to the only telephone number that it had for plaintiff and learned that plaintiff's telephone number had been disconnected and that there was no new telephone number or listing. The representative also tried to locate a new telephone number in the phone book but was unsuccessful. On July 14, 1993, AOI mailed a notice of cancellation notice of the policy to plaintiff, the cancellation being effective as of August 17, 1993. The notice was sent to the Milwaukie address.

On August 24, 1993, plaintiff's president again telephoned AOI and talked with AOI's representative. He told the representative that plaintiff had a new address and phone number and gave that information to the representative. The representative testified that her practice was to inform customers of the status of their policies. Thus, she believes that she informed plaintiff that its insurance policy had been canceled on August 18, 1993, because of the failure to file payroll records, but she could not recall whether she did so and her notes do not indicate that she did. According to the representative, plaintiff's president did not represent that he had earlier reported a change of business location to AOI.

156 Or App 415> On December 21, 1993, plaintiff's president again called AOI and talked with its representative. By that time, according to plaintiff's president, one of U.S. West's employees had been injured and had filed a workers' compensation claim. Plaintiff's president testified that he had been told by AOI that the claim had been denied and that he then called to inquire as to the reason for the denial. AOI informed him that the policy had been canceled due to the failure of plaintiff to file the required payroll reports. AOI's representative testified that plaintiff's president said that he had thought he sent a mailing address change to AOI. The representative checked her computer records and determined that the only address that AOI had on file was the original address in Milwaukie. The representative also checked its file, where a copy of plaintiff's policy was maintained, and found no letter or any indication of any business location change. The representative also testified that plaintiff's president told her that he would check his files and report back to her, but she never heard from him after that conversation. Plaintiff's complaint in this action was filed in November 1994.

In his testimony, plaintiff's president recalled three different conversations with AOI representatives, and he said that he had supplied a new address for plaintiff. He also claimed to have sent a change of address letter to AOI in March 1993. He produced a copy of a letter that he said he had sent to AOI in December 1993. The December letter stated that "our address changed in 1993." He testified that the representation in the letter that plaintiff's location changed in 1993 was a typographical error.

The issue of when plaintiff gave notice to AOI of the change of address of its business was tried to the trial court. The trial court ruled that the policy had been ineffectively canceled and was still in effect at the time of the workers' compensation injury. The court reasoned that, because AOI had received a check for the premium on March 30, 1993, which had plaintiff's new address on it, AOI had legal notice of plaintiff's new address.[1] The trial court entered judgment **<156 Or App 415/416>** declaring the policy of insurance in full force and effect; the trial court ordered SAIF to file a guarantee contract with the state of Oregon on plaintiff's behalf, to be effective for a period including the time during which the workers' compensation claim had been made and awarded plaintiff attorney fees.

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[1] The court explained:

"It seems to me that as early as December 8th, '92, AOI was aware that [plaintiff's president] had changed his business address. There's an entry on Exhibit 106 that says 'Will send in address change with payment.' Presumably the payment came, and perhaps the address change did not come, but we do know that from the post office record he changed his address on the 30th, two and a half months before, or two months plus before this 12-8-92 date. If he gets, which I have to assume that he did, the mailing that preceded his submission of a new check in the exact amount of the refigured renewal of the policy, we don't know when that was sent because it's undated from AOI.

On appeal, SAIF makes several assignments of error, including the argument that the trial court erred in finding that the policy remained in force. SAIF argues that the trial court erred as a matter of law when it determined that AOI had not effectively canceled the insurance policy. Specifically, it asserts:

> "Rather, the trial court based its conclusion that the policy remained in force on a relatively limited set of facts: (1) that AOI was aware that [plaintiff's president] had changed his business address; (2) that the check submitted for payment of the policy (and received by AOI) included the new address printed on it; (3) that a payroll report submitted to the old address was returned as undeliverable on a non-working address; and (4) that AOI sent the cancellation notification without any refund to the same non-working address."

156 Or App 417> SAIF concludes that the facts, as found, do not support the legal conclusion that the policy remained in force.

ORS 656.427 governs the termination of a guaranty contract or surety bond liability by a workers' compensation insurer. Specifically, ORS 656.427(3) provides, in part:

> "Notice * * * shall be given by mail, addressed to the employer at the last-known address of the employer. If the employer is a partnership, notice may be given to any of the partners. If the employer is a limited liability company, notice may be given to any manager, or in a member managed limited liability company, to any of the members. If the employer is a corporation, notice may be given to any agent or officer of the corporation under whom legal process may be served."

Insurance policies are contractual in nature and are construed as ordinary business contracts. Their interpretation is a question of law and, in interpreting the meaning of a policy, our "goal is to ascertain the intent of the parties, based on the terms and conditions of the policy." *St. Paul Fire v. McCormick & Baxter Creosoting*, 324 Or 184, 192, 923 P2d 1200 (1996). However, when a provision of an insurance contract is regulated by statute, the intent of the legislature rather than the intent of the parties to the contract controls. *Windsor Ins. Co. v. Judd*, 321 Or 379, 384, 898 P2d 761 (1995). Thus, ORS 656.427(3) must be read with the provisions of the policy to determine the obligations under both.

The first sentence of ORS 656.427(3) imposes the requirement that a notice of cancellation be sent to the last known location of the employer. The rest of the statute provides to whom the notice must be sent at that location, depending on the nature of the business entity. The statute does not prescribe the manner in which the last known address will be ascertained, and it does not preclude parties to an insurance agreement from agreeing on how notice of cancellation will be given. Presumably, the legislature has left that issue to the individual parties to each policy. The statute requires only that notice be given to the "last-known address of the employer." We conclude that there is no conflict between the language of the statute and the terms of the policy in this case unless AOI knew or had constructive **<156 Or App 417/418>** knowledge of plaintiff's new address, but instead, relied on the address listed in the policy.

"But as a response to that, he did send in a check on March 29th, which they show receiving March 30th on the back of the check, in the exact amount of the next year's premium, '93 to '94. And while he claims that he sent in an address change at the same time, which as I said may be suspect, at least the check itself had a new address on it, and the processor at AOI was aware that there would be a new address because she was told that.

"* * * * *

"So I'm finding that irrespective of [plaintiff's president's] testimony and his dated letters, which we all have some suspicions about, including the date of the claim -- he said he contacted them on the 22nd of December when they got the letter on the 23rd, things we talked about at trial last week -- nevertheless, I'm going to determine that the insurance company did not effectively cancel his policy, and at the time that this claim was made, it should have been honored, providing he makes the payments and submits the payroll report and any other appropriate conditions that are required prior to the payment or investigation, at least the claim for payment."

We do not discern from the trial court's ruling any finding that a representative of AOI who was charged with the responsibility of issuing the notice of the cancellation was actually aware of plaintiff's new address or had information that should have made AOI aware of plaintiff's new address. Apparently, the trial court was suspicious of plaintiff's testimony that it had furnished its new address to AOI. Rather, it based its ruling on AOI's information that plaintiff had changed the location of its business from Milwaukie, that AOI's mailings were returned when sent to that address and the fact that plaintiff's check for the annual premium was submitted to AOI with the new address on it. The trial court concluded from these facts that AOI should have investigated further to discover plaintiff's new address.[2] However, neither the policy nor the statute imposes such a duty. The statute requires the notice to be sent to the "last known" address. There is nothing in the language of the statute that requires an insurer to undertake the affirmative duty of discovering a new address that has not been furnished by the insured. When the language of the statute is considered with the provisions of the policy, the combined effect is that the address to which a notice of cancellation is to be sent will be determined by reference to the Information Page of the policy. Thus, the burden is on the insured to keep the insurer informed of the insured's address.

Moreover, submitting a check with a new address on it to the accounting department of an insurer for payment of a premium does not provide, in and of itself, reasonable notice of a new address to a representative of the insurer who is authorized to make the change in the policy. That is particularly apparent when the policy instructs the insured to provide its actual address. AOI, as a party to the policy, was entitled to rely on the change of address provisions of the policy <156 Or App 418/419> unless reasonably put on notice in another manner of plaintiff's new address. To add the additional requirement under the statute that an insurer has an affirmative obligation to conduct an investigation to learn of a new address, as the dissent suggests, is in contravention of ORS 174.010.[3] It would add language to the statute that the legislature did not enact.

In sum, we agree with SAIF's argument that the facts as relied on by the trial court do not support the legal conclusion that the cancellation is ineffective. On remand, the trial court must determine whether the change of address claimed to be given was actually given and whether, if given, substantially complied with the change of address requirements of the statute and the policy.

Reversed and remanded.

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[2] In fact, AOI's representative testified that she tried to contact plaintiff by calling the telephone number that plaintiff had given. She learned that plaintiff's telephone had been disconnected. She then tried to locate a new telephone number for plaintiff, but no number was listed in the directory.

[3] ORS 174.010 provides:

"In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all."

ARMSTRONG, J., dissenting.

The majority concludes that the evidence is insufficient to support a finding that defendant AOI had actual notice of plaintiff's new address and, therefore, that the address to which AOI sent the notice of cancellation was the "last known address" referred to in ORS 656.427(3).[1] Because **<156 Or App 419/420>** I conclude that the statutory phrase "last known address" incorporates a duty of reasonable diligence to determine plaintiff's new address before sending the notice of cancellation, I dissent.

We have not had occasion to construe ORS 656.427(3). The pertinent language of the statute reads: "Notice under this section shall be given by mail, *addressed to the employer at the last-known address of the employer.*" (Emphasis added.) Under the terms of the parties' contract for insurance, a mailing to the "address shown in item 1 on the Information Page" is sufficient notice of cancellation. The trial court held that, where defendants had actual notice that the address on the Information Page was incorrect, a mailing to that address could not satisfy the notice requirements of ORS 656.427(3), even though it may have satisfied the policy requirements. The court reasoned:

> "* * *[Plaintiff] did send in a check on March 29th, which [AOI] show[s] receiving March 30th on the back of the check, in the exact amount of the next year's premium. * * * [A]t least the check itself had a new address on it, and the processor at AOI was aware that there would be a new address because she was told that.
>
> "Then a payroll report is submitted to the old address and returned by the post office as undeliverable on a non-working address, and even with that information, the next communication from AOI is to the same stale and not working address[.]
>
> "I believe that the policy was ineffectively canceled. I believe the agency should have done more to ascertain where they ought to be mailing their materials, particularly their cancellation notice when they already know the address is no good."

In response to defendants' retort that they had done all that was required under the policy by sending the cancellation to the address listed in the policy, the court stated:

> "I find it facile, frankly, to send a cancellation notice to an address that the party knows is no good and then say, **<156 Or App 420/421>** well, that's all we had, that we're just fulfilling our duties under the contract, we don't have any more obligation other than what it says no matter what we know about the quality of the address."

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[1] ORS 656.427 provides:

"(1) 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 written notice of termination. A notice of termination shall state the effective date and hour of termination.

"(2) An insurer may terminate liability under this section as follows:

"(a) If the termination is for reasons other than those set forth in paragraph (b) of this subsection, it is effective at 12 midnight not less than 30 days after the date the notice is received by the director.

"(b) If the termination is based on the insurer's decision not to offer insurance to employers within a specific premium category, it is effective not sooner than 90 days after the date the notice is received by the director.

"(3) Notice under this section shall be given by mail, *addressed to the employer at the last-known address of the employer.* If the employer is a partnership, notice may be given to any of the partners. If the employer is a limited liability company, notice may be given to any manager, or in a member managed limited liability company, to any of the members. If the employer is a corporation, notice may be given to any agent or officer of the corporation under whom legal process may be served." (Emphasis added.)

Defendants argue, and the majority appears to agree, that, without clear notice from plaintiff that its address had changed and that the address on the premium payment check should be noted as the new and correct address, it was unreasonable for the trial court to hold that AOI should have changed its records accordingly. Because the SE 31st Street address was the last address AOI had on file, and because the contract stated that the address on the policy's Information Page was the address to which notice of cancellation would be sent, the majority concludes that the cancellation notice was effective. The majority further concludes that the contractual language is consistent with the statutory requirement that notice be sent to employer's "last-known address." I disagree.

This case is similar in many respects to *Morris v. Dept. of Revenue*, 320 Or 579, 889 P2d 1294 (1995), in which the Supreme Court construed the phrase "last-known address" in ORS 305.265(11). Under that provision, the 90-day period for appeals to the Department of Revenue from a determination and assessment notice begins to run when notice has been mailed "to the person at the person's last-known address." The court held that, once the department had actual notice that plaintiff's address had *changed*, the last-known address was no longer the address the department had on file, but, rather, the new address, even if the department did not yet have actual notice of the new address:

> "'Last known address' ordinarily refers to the address provided on the last Oregon income tax return filed by the taxpayer. * * * *However, the 'last-known address' changes if the department has actual notice that the taxpayer's address has changed. Once the department has such notice, it is required to use reasonable diligence in ascertaining the taxpayer's last-known address.*"

Id. at 583-84 (citations omitted; emphasis added). In that case, the court found that the department had exercised **<156 Or App 421/422>** reasonable diligence by contacting the Motor Vehicles Division for plaintiff's address after the department had been notified of the address change by the Internal Revenue Service. *Id.* at 584.

I am persuaded that the notice provision of OR 656.427(3) is sufficiently similar to that of OR 305.265(11) to apply the Supreme Court's analysis in *Morris* to this case. The trial court found that AOI made no real attempt to ascertain plaintiff's correct address, even though three separate mailings had been returned to AOI as undeliverable. Applying the reasonable diligence standard from *Morris*, I conclude that the trial court did not err in holding that the cancellation was ineffective.

For the reasons given, I dissent.

Cite as 156 Or App 430 (1998) October 7, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Basilio A. Sandoval, Claimant.

BASILIO A. SANDOVAL, Petitioner,
v.
JAMES KJELDE DAIRY and COUNTRY COMPANIES, Respondents.
(WCB 97-00224; CA A99933)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 9, 1998.
Dale C. Johnson argued the cause for petitioner. With him on the brief was Malagon, Moore & Jensen.
Chess Trethewy argued the cause for respondents. With him on the brief was Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
EDMONDS, J.
Affirmed.

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156 Or App 432> Claimant seeks review of an order of the Workers' Compensation Board in which he receives no award for unscheduled permanent partial disability (PPD) for his lumbar strain. ORS 656.298. Claimant contends that the order of the Board is not adequate for judicial review and that, even if it is adequate for review, there is not substantial evidence to support the Board's findings. We affirm.

We state the facts as the Board adopted them from the administrative law judge's (ALJ's) opinion. Claimant is a herdsman and milker who had been employed at employer's dairy. After suffering a compensable injury, he consulted several physicians for treatment and underwent various tests. In September 1995, his employer accepted a claim for lumbar strain, and a medical report contained measurements that indicated that claimant had limited range of motion in his lower back. In May 1996, claimant was diagnosed with either a pain or somatization disorder. Thereafter, claimant was determined to be "medically stationary concerning his physical injury and capable of performing light work" and a determination order issued, awarding him 17 percent unscheduled PPD. That order was subsequently amended to reduce the percentage of unscheduled PPD to zero based on a finding that claimant's condition was not chronic.

Dissatisfied with the amended determination order, claimant sought reconsideration by the Department of Consumer and Business Services (DCBS). In October 1996, medical arbiters for DCBS examined claimant and reviewed his claim. The arbiters measured claimant's active range of motion in his lumbar spine. The examination included measurements for lumbar flexion, lumbar extension, lumbar right lateral flexion and lumbar left lateral flexion. The measurements indicated that claimant had a reduced range of motion in his lower back. The examiners also performed a straight-leg-raising test and responded to specific questions, including the following:

> Question: "4. *If findings are due to the injury AND due to other unrelated causes, describe, based upon your medical judgement, the percentage of* **<156 Or App 432/433>** *impairment due to the accepted condition(s). Include rationale for your decision.*
>
> Response: "Upon our examination, he has no objective loss due to the injury.
>
> " * * * * *
>
> Question: "6. *If any findings are considered invalid, provide rationale and detailed reasoning in accordance with Bulletin 239 and the AMA Guides; include anatomic findings if applicable.*

Response: "The findings are considered valid, with the exception of the straight leg raising validity check.

Question: " 7. *Please describe the worker's residual functional capacity with reference to the accepted condition(s) and/or sequelae in accordance with the following*:

" * * * * * *

"(e) *State whether the worker has permanent restrictions in working the same number of hours that were worked prior to the injury.*

Response: " There is no objective evidence of injury requiring permanent restrictions in working the same number of hours that were worked prior to the injury.

"Of note, it seems there is a psychological component to this injury, as has been found previously, however, we can find no objective orthopedic or neurologic injury based on the examination today, in the records that are available." (Bold and italics in original.)

On reconsideration by DCBS that included the arbiters' report, the amended determination order was affirmed, and claimant appealed. On appeal, the ALJ awarded claimant 28 percent unscheduled PPD. Employer sought review, and the Board reversed the ALJ's order, affirming DCBS's order on reconsideration that had awarded claimant no PPD. Claimant seeks review by this court of the Board's order.

Claimant argues that he is permanently impaired due to the injury and that, based on the arbiters' report, the **<156 Or App 433/434>** Board could not find otherwise. He asserts that the Board failed to find a psychological component of the injury; incorrectly assumed that a psychological component was still present; assumed that it was unrelated to the injury; and failed expressly to attribute the impairment findings to causes other than the injury. In addition, he argues that the Board misconstrued the arbiters' response to Question 6. Thus, according to claimant, the Board's order is inadequate for judicial review because it failed to reconcile its finding that claimant had not established impairment due to the injury with the evidence in the record.

An order is adequate for judicial review if it contains findings of fact and reasoning and conclusions of law based on the findings. *Campos v. Hood River Care Center*, 104 Or App 261, 264, 799 P2d 1152 (1990). Substantial evidence exists to support a factual finding "when the record, viewed as a whole, permits a reasonable person to make the finding." *Topolic v. SAIF*, 122 Or App 94, 97, 857 P2d 152 (1993).

In its order, the Board referred to a May 1996 report in which claimant was diagnosed with a pain syndrome. According to the psychiatrist's report, the syndrome was caused by claimant's "psychological makeup, his cultural expectations, and his general medical condition, [and] the general medical condition being caused by the wear and tear on his musculoskeletal system from the kind of work that he did." At the same time, a physical examination indicated that claimant demonstrated considerable symptom magnification. The Board considered this evidence in conjunction with the arbiters' report. The Board could reasonably have understood reference in the arbiters' report to a psychological component to refer to the psychiatrist's diagnosis of pain syndrome. Also, the Board could have reasonably construed the arbiters' statements to mean that the psychological component existed at the time of their examination and that they attributed any impairment to the psychological component since they found "no objective orthopedic or neurologic injury based on the examination today, in the records that are available." Although the arbiters did not expressly attribute any impairment to the "psychological component," the Board could also have reasonably interpreted their statements in **<156 Or App 434/435>** the context of the evidence in the record to have that meaning.

The arbiters' report also stated that "[t]he findings are considered valid, with the exception of the straight leg raising validity check." The meaning of this statement is ambiguous because the arbiters did not describe the effect of an invalid straight leg raising test on their other range of motion findings. Nevertheless, the Board undertook to interpret its meaning in the context of the other evidence before it when it stated that "[t]he medical arbiter panel commented in their report that the straight leg raising

check related to claimant's range of motion findings indicated invalidity of the findings." In its conclusion, the Board ruled:

> "The medical arbiter panel noted that there was a psychological component to claimant's injury and that there was no objective orthopedic or neurologic injury by examination or their record review. * * * They reported that the straight leg raising check yielded invalid findings. * * * They also stated that claimant had no objective loss due to the injury. * * * Under these circumstances, we conclude that the medical arbiter's findings of reduced range of motion in the low back is not persuasive evidence of impairment due to the injury. Because claimant has not established impairment due to the injury, no award of unscheduled permanent disability shall be allowed."

We hold that the Board could have reasonably interpreted the arbiters' report as a whole to mean that the range of motion findings were invalid in light of the invalidity of the straight-leg-raising test, the reference in the report to a psychological component and their statement that there was no objective loss due to the injury. In that light, the Board's order is adequate for judicial review because it contains factual findings from which its conclusions reasonably follow. In the same respect, the Board's findings are supported by substantial evidence. In sum, the Board was not persuaded by the evidence that claimant's low back impairment was the result of his lumbar strain. Accordingly it did not err when it refused to award PPD.

Affirmed.

Cite as 156 Or App 454 (1998) October 7, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Medical Treatment Dispute of Alyce Langley, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
ALYCE LANGLEY and DEPARTMENT OF CONSUMER & BUSINESS SERVICES, Respondents.
(H97-043; CA A98326)

Judicial Review from Workers' Compensation Division.

Argued and submitted July 15, 1998.

Cynthia A. Wiens argued the cause for petitioner. With her on the brief was Cowling, Heysell, Plouse & Ingalls.

Dale C. Johnson argued the cause for respondent Alyce Langley. On the brief were Christine I. Jensen and Malagon, Moore & Jensen.

Denise Fjordbeck, 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 Michael D. Reynolds, Solicitor General.

Before Edmonds, Presiding Judge, and Deits, Chief Judge, and Armstrong, Judge.

ARMSTRONG, J.

Affirmed.

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156 Or App 456> Employer seeks review of an order of the Workers' Compensation Division in which the Director concluded that certain medical services performed in 1996 were diagnostic services for a compensable injury suffered by claimant in 1984. Employer contends that the Director did not have jurisdiction over the medical services claim because, in a separate proceeding before the Workers' Compensation Board, that claim had been accompanied by a claim for compensation for a combined or consequential condition. We conclude that the Director did have jurisdiction over the medical services claim and affirm.

Claimant suffered a compensable lumbosacral strain in 1984 while she was working for employer as a custodian. The claim was closed in 1988. Between 1986 and 1994, claimant underwent a series of diagnostic tests to determine whether her injury was causing the radiating pain that claimant was experiencing in her left lower extremity and foot. None of the tests revealed either disc herniation or nerve root compression, conditions that could have been linked to the original injury. Employer nevertheless paid for those tests. In 1994, claimant's treating physician informed employer that claimant was "medically stationary and there are no further diagnostic or curative procedures possible." Subsequently, in 1996, the same physician ordered a CT scan and myelogram, because claimant continued to complain of the radiating pain. Again, there was no sign of disc herniation or nerve root compression. There was, however, evidence of a degenerative disc condition. Claimant's physician administered epidural steroids as treatment for the disc degeneration. Claimant submitted a claim for medical services to employer. Employer denied the claim, stating:

> "Over the last few months, you have been receiving treatment for low back problems. It is the position of [Roseburg Forest Products] that the current treatment received is not a result of your industrial injury occurring over eleven years ago.
>
> "Your current claim for treatment is denied."

156 Or App 457> Claimant filed challenges to the denial with both the Workers' Compensation Board and the Workers' Compensation Division of the Department of Consumer and Business Services (the Director). The Board hearing took place on January 29, 1997 and the parties submitted written closing arguments on March 24, 1997. The record was closed on April 3, 1997, and the administrative law judge (ALJ) issued an opinion and order on May 5, 1997. The hearing with the Director took place on April 4, 1997, and the ALJ in that hearing issued a proposed and final contested case hearing order on April 21, 1997.

In the hearing before the Board, claimant argued that the medical services were directed at the earlier compensable injury *and* that her current condition was a compensable result of the earlier injury, so that both the diagnostic tests and the epidural steroid injections were compensable.[1] The ALJ in that proceeding concluded, and the Board affirmed, that claimant's earlier compensable injury was not the major contributing cause of her current condition and, consequently, that employer was not required to pay for treatment of that condition.[2] The ALJ declined to address the medical services claim, stating:

> "It is my opinion that new legislation has clearly granted *exclusive* jurisdiction over this matter to the Director[;] therefore I do not address the issue of whether certain medical treatment billings should be paid."

(Emphasis in original.) The record does not indicate that employer sought Board review of the ALJ's refusal to address the medical services claim.[3]

156 Or App 458> At the hearing before the Director, the sole issue was whether the diagnostic services were related to claimant's original compensable injury. Employer contended that the ongoing compensability proceedings before the Board stripped the Division of jurisdiction over the medical services claim. The ALJ in that proceeding (a different ALJ from the one conducting the Board hearing) disagreed, concluding that the Director had exclusive jurisdiction over the claim, because employer's denial letter

> "did not deny the compensability of any condition. Rather, the letter denied *treatment* on the basis that the treatment was not related to the accepted condition."

(Emphasis in original.) In reaching that decision, the ALJ relied on our decision in *SAIF v. Shipley*, 147 Or App 26, 934 P2d 611 (1997). The Supreme Court has since affirmed our decision. *SAIF v. Shipley*, 326 Or 557, 955 P2d 244 (1998). On June 19, 1997, the Director issued a final order affirming the ALJ's decision. Employer seeks review of that order.

On review, employer argues that the Director was stripped of jurisdiction over the medical services claim once that claim was combined with a claim for compensation for a new condition. Employer further argues that, even if the issue were properly before the Director, the wrong standard was applied in determining whether the services were covered by employer's obligation to pay for services related to the original compensable injury.

Our resolution of the jurisdictional issue requires us to examine two separate statutes, ORS 656.245[4] and ORS **<156 Or App 458/459>** 656.704, in light of the Supreme Court's decision in *Shipley*. We begin with the text of the statutes. ORS 656.704(3) is a jurisdictional statute, establishing the respective authority of the Director and the Board to hear certain claims. Under the terms of the statute, the Board has jurisdiction over "matters concerning a claim," which are defined as "those matters in

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[1] According to the opinion and order issued by the ALJ who heard the case on behalf of the Board, employer had argued that the medical services claim was "exclusively within the jurisdiction of the Director of the Department of Consumer [and] Business Services" and that the Board had no jurisdiction to address it. Neither party has challenged that statement. Claimant does not argue that the position taken by employer before the Board estops employer from asserting, as it does here, that the Director did not have jurisdiction over the claim, so we do not consider that issue.

[2] Claimant has not sought review of that decision.

[3] Given employer's position on the issue at the hearing, *see* note 1, it presumably could not have done so.

[4] ORS 656.245 provides, in pertinent part:

"(1)(a) For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires, subject to the limitations in ORS 656.225, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury.

"* * * * *

"(c) Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:

which a worker's right to receive compensation, or the amount thereof, *are directly in issue.*" (Emphasis added.) The statute further provides that the Board does not have jurisdiction over medical services disputes arising under ORS 656.245, except as otherwise provided by that statute. Under ORS 656.245(6), the Board has jurisdiction only over those medical services disputes in which the denial of medical services is based on a denial of the compensability of the underlying claim. Otherwise, all claims for medical services under ORS 656.245 come within the exclusive jurisdiction of the Director. ORS 656.704(3).

In *Shipley*, the Supreme Court reviewed the texts of the statutes and concluded that, in a case where the compensability of an underlying claim was no longer at issue before the Board, the Board was stripped of any jurisdiction it may have had to address the claim for medical services. 326 Or at 564-65. In that case, the compensability of the underlying claim was no longer at issue because the claimant chose at the hearing to argue only that the medical services for which coverage was sought were directly and materially related to his original compensable injury. The court reasoned that

> "[t]he issue that the Hearings Division properly could decide and that the Board properly could review was SAIF's denial of the compensability of claimant's 1994 injury, either as an aggravation of the compensable 1989 injury or **<156 Or App 459/460>** as a new compensable injury. When the hearing began, however, claimant chose not to challenge the denial of compensability. Instead he chose to pursue a different theory, linking the post-1994 medical services to the underlying, compensable 1989 claim. * * * When the issue was thus reframed, the administrative law judge and the Board had no authority to decide it. The statutes contain no provision for transferring a case from the Board to the Director. That being so, dismissal was required." *Id.* at 565.

Although, at first glance, it would appear that the outcome in this case is controlled by *Shipley*, the issue is made more complex by the manner in which claimant's claims were presented to the Board. Claimant appears to have made two separate arguments: (1) that her degenerative disk condition is attributable to her original compensable injury and, therefore, that any diagnostic, palliative or curative treatments for that condition are compensable; and (2) that the diagnostic procedures (the CT scan and the myelogram) were directly and materially related to her original compensable injury. The first issue was clearly within the jurisdiction of the Board as a matter concerning a claim under ORS 656.704(3). The second issue, had it been presented alone, equally as clearly would have been outside the jurisdiction of the Board. *Shipley*, 326 Or at 564. The analytical difficulty springs from the fact that, if the ALJ and the Board had concluded that the degenerative disc condition was compensable, then all the treatments, including the diagnostic procedures, would have been covered and there would have been no question that the Board and not the Director had the authority to address that issue. However, once the ALJ and the Board concluded that the degenerative disc condition was *not* compensable, the issue remained as to whether the diagnostic procedures were related to the earlier compensable injury. Again, had that issue been the *only* issue presented, it would have been within the exclusive jurisdiction of the Director. *Id.*

Neither the text of the applicable statutes nor the Supreme Court's interpretation of those statutes in *Shipley* offers a clear solution. Accordingly, we turn to the legislative history in an effort to discern the legislature's intent.

156 Or App 461> ORS 656.704(3) was revised in 1995 as part of an overall revision of the Worker's Compensation Law. *See* Or Laws 1995, ch 332, section 50 (SB 369). At that time, there had been a number of court cases addressing the respective authority of the Board and the Director to decide claims, and the drafters of the new legislation sought to correct what they considered to be an erroneous

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"* * * * *

"(H) Services that are necessary to diagnose the worker's condition.

"* * * * *

"(6) If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550."

grant of jurisdiction over certain medical services claims to the Board rather than to the Director. Tape recording, Senate Committee on Labor and Government Operations, SB 369, Feb 1, 1995, Tape 19, Side A (statement of Jerry Keene). Mari Miller, then the manager of the Dispute Resolution Section of the Workers' Compensation Division, testified that the purpose of placing claims for medical services within the exclusive jurisdiction of the Director was to ensure that claims for treatment were processed as quickly as possible. Tape Recording, House Committee on Labor, SB 369, March 8, 1995, Tape 48, Side A. She further testified that the Director was the appropriate arbiter of such claims because the claims involve purely medical decisions and not the evaluation of evidence and legal arguments, such as those presented to the Board. *Id.*

Although the testimony of interested parties may not be the best evidence of legislative intent, it still offers us some insight into the practicalities of the claims process. *See Mallon v. Employment Division*, 41 Or App 479, 483, 599 P2d 1164 (1979) ("Although the testimony of a witness before a legislative committee should be cautiously used in determining legislative intent, it is some indication of the legislation's purpose.") It further allows us better to understand why, once the issue of compensability has been dispensed with, either because the claimant has chosen not to contest it, as in *Shipley*, or because the issue has been decided against the claimant, as in this case, any remaining medical services claims are to be decided by the Director.

Claims before the Board and before the Director are treated very differently. The Director has the resources to review a claim for medical services in order to ensure that appropriate treatment is delivered to the claimant in a timely manner, whereas a claim submitted to the Board may result in a lengthy delay in the delivery of or payment for needed services. Tape Recording, House Committee on Labor, SB **<156 Or App 461/462>** 369, March 8, 1995, Tape 48, Side A (statement of Mari Miller). With that in mind, we conclude that it was the legislature's intent that disputes over medical services related to compensable claims be decided by the Director, no matter when or how those disputes first arose. Accordingly, the Director had the authority to review this claim even though it originally had been raised in conjunction with a claim that came within the Board's jurisdiction. That is not to say that, had the Board concluded that claimant's degenerative disc condition *was* compensable, it could not have ordered employer to pay for the diagnostic services; rather, we hold only that, once the Board concluded that the new condition was *not* compensable, it could not address the issue whether the diagnostic tests were materially related to the original compensable injury. *That* determination was within the exclusive jurisdiction of the Director.

Employer next argues that the Director applied the wrong standard to determine whether the diagnostic tests were sufficiently related to claimant's compensable injury to warrant coverage. The Director affirmed and adopted the ALJ's findings and conclusions as to the medical services issue. The ALJ had concluded that

> "[m]edical services necessary to diagnose a worker's condition are compensable. ORS 656.245(1)(c)(H). '[I]f diagnostic services are necessary to determine the cause or extent of a compensable injury, the tests are compensable whether or not the condition that is discovered as a result of them is compensable.' *Counts v. International Paper Co.*, 146 Or App 768, 771[, 934 P2d 526] (1997), *Brooks v. D & R Timber*, 55 Or App 688, 692[, 639 P2d 700] (1982). Diagnostic services for the purpose of determining a causal relationship, if any, between an accepted condition and the worker's condition are therefore compensable.
>
> "Dr. Kitchel's impression on June 28, 1996, was that claimant's low back and leg complaints were related to her industrial injury. He ordered diagnostic testing to obtain more information as to what was affecting claimant. Claimant's visit to Dr. Kitchel, the myelogram, and the CT scan, were appropriate for the purpose of determining whether claimant's accepted low back strain and leg condition were causing her complaint's. Therefore, the services are compensable as necessary diagnostic services."

We conclude that there is substantial evidence in the record to support the ALJ's finding that the tests were for the purpose of determining the extent of the original compensable injury and not, as employer contends, for the purpose of establishing the existence of a new or consequential condition. Accordingly, employer is obligated to pay for those tests under ORS 656.245(1)(a) and ORS 656.245(1)(c)(H). *Counts*, 146 Or App at 771; *Brooks*, 55 Or App at 692.

Affirmed.

Cite as 156 Or App 499 (1998) October 14, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David F. Lemus, Claimant.

GREENBRIAR AG MANAGEMENT and FARMERS INSURANCE GROUP, Petitioners,
v.
DAVID F. LEMUS, Respondent.
(96-02392; CA A98383)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 5, 1998.
Vera Langer argued the cause for petitioner. With her on the briefs was Scheminske, Lyons & Bussman, LLP.
Richard F. McGinty argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
HASELTON, J.
Affirmed.
Linder, J., dissenting.

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156 Or App 501> Insurer seeks review of an order of the Workers' Compensation Board setting aside insurer's revocation of acceptance and concomitant "back-up" denial of claimant's low back injury claim. ORS 656.262(6)(a). The Board determined that, although claimant had misrepresented his medical history, insurer failed to show that those misrepresentations could reasonably have affected its decision to accept the claim. The Board further rejected insurer's alternative and related argument that "later obtained evidence" concerning claimant's medical history justified the "back-up" denial. We conclude that the Board did not err in either regard and affirm.

The Board found the following material facts: On December 2, 1995, claimant sought treatment from Dr. Jack Buchanan in the Salem Hospital's emergency room, complaining of low back and left hip pain. Claimant told Buchanan that he had been injured on November 29, 1995, when he lifted a Christmas tree while working for employer. Claimant also told Buchanan that he had no history of back problems.

On December 4, 1995, claimant received treatment from Dr. Janet Neuburg, who diagnosed a back strain. Although claimant admitted that he had a prior workers' compensation claim from an auto accident, he told Neuburg that he did not have any prior back problems. On the same day, claimant completed a medical report form, answering "no" to the question, "Was the same body part injured before?"

Claimant's answers to Buchanan and Neuburg, as well as his response on the report form, were, in fact, misrepresentations. In particular, contrary to his statement that he had not previously injured his back, claimant had compensably injured his low back in a motor vehicle accident while working for a different employer on April 28, 1988. As a result of that injury, claimant had been temporarily disabled from April 1988 until mid-1989, with treatment for that injury continuing through at least October 1990, and had **<156 Or App 501/502>** received an award of 52 percent unscheduled permanent partial disability for that injury. In December 1989, claimant had filed an unsuccessful aggravation claim pertaining to the April 1988 injury. In December 1990, claimant had filed a claim for a low back, left leg, and right ankle injury allegedly incurred while working for a different employer. That claim was resolved through a disputed claim settlement.

On January 24, 1996, insurer's claims representative sent a letter to claimant's treating physician, Neuburg, requesting information concerning claimant's condition. That letter included the following question and information:

> "Were you aware Mr. Lemus had at least two prior claims in 1988 and 1990? Please note we are in the process of obtaining the records and will provide your office with a copy of

> the records. The first claim was in 1988 processed by SAIF. The injury was lumbo/sacral strain. He was treated by Don Poulson, M. D. The claim was denied. A second claim occurred in 1990. It also appears to be for overexertion resulting in multiple parts sprain/strain."

On February 13, 1996, before receiving the additional records referred to in the January 24 letter and, apparently, before receiving Neuburg's response to that letter, insurer accepted the claim for nondisabling lumbar strain. There is no evidence or explanation in the record as to why insurer accepted the claim at that time. The 90-day statutory period for accepting or denying claims, ORS 656.262(6)(a), did not expire until March 6, 1996.

After accepting the claim, insurer received the records concerning claimant's prior claims. On March 1, 1996, insurer revoked its prior acceptance and issued a "back-up" denial pursuant to ORS 656.262(6)(a). The notice of revocation and denial stated, in part, that, after having accepted the claim,

> "[W]e have received a significant volume of information which demonstrates that the history you provided to your examining and treating physicians misrepresented your true medical history regarding prior lower back disorders and symptoms. Having now received accurate information **<156 Or App 502/503>** regarding your health history, we have come to the conclusion that your alleged injury which allegedly occurred on or about November 27, 1995 is not compensable."

The Board set aside insurer's revocation of acceptance and "back-up" denial. In so holding, the Board rejected insurer's arguments that the revocation and denial were proper under ORS 656.262(6)(a) either because (a) claimant had materially misrepresented his medical history; or (b) the records and reports received after acceptance constituted "later obtained evidence" that the claim is not compensable.

With respect to misrepresentation, the Board found that claimant was, in fact, untruthful concerning his prior low back injuries and the related 1988 and 1990 claims and, thus, that he "misrepresented his medical history." Nevertheless, the Board determined those misrepresentations were not "material" because insurer had failed to show that the misrepresentations "could have reasonably affected" its decision to accept the claim. *See Ebbtide Enterprises v. Tucker*, 303 Or 459, 464, 738 P2d 194 (1987). The Board explained:

> "It is apparent from the record that, at the time of the January 24 letter to Dr. Neuburg, the insurer did not have every available document concerning claimant's prior medical history. The information also possibly is at least partly incorrect because there is no evidence that SAIF denied the 1988 claim. What the letter does show, however, is that the insurer knew that claimant had at least one previous injury to his low back and had received treatment for it. The letter also shows that claimant had been involved in claims in 1988 and 1990. Thus, the insurer knew *before* it issued its acceptance that claimant was not truthful when he told his treating physicians that he had not previously injured his low back and that he omitted to inform them of the 1990 claim. Because the insurer was aware of this misrepresentation and nevertheless issued its acceptance of a lumbar strain, we conclude that the insurer failed to show that claimant's misrepresentation 'could have affected' its decision to accept." (Emphasis in original; footnotes omitted.)

With respect to the "later obtained evidence" argument, the Board acknowledged that "the insurer did not have claimant's entire available medical record and obtained the **<156 Or App 503/504>** majority of such evidence after it issued its acceptance." Nevertheless:

> "The January 24, 1996 letter to Dr. Neuburg * * * shows that the insurer knew the basic facts of claimant's 1988 and 1990 claims and that claimant previously had been treated for a low back injury although [the insurer] did not realize the extent of the prior injuries. This information may have indicated that the claim was not compensable because claimant was untruthful concerning his prior medical history. Thus, because the insurer had evidence at the time of acceptance that the claim was not compensable, we also conclude that its revocation of acceptance and issuance of the denial were not proper."

On review, insurer reiterates its "misrepresentation" and "later obtained evidence" arguments. Those arguments are based on ORS 656.262(6)(a). The portion of the statute pertaining to misrepresentations provides, in part:

> "The insurer or self-insured employer may revoke acceptance and issue a denial at any time when the denial is for fraud, misrepresentation or other illegal activity by the worker. If the worker requests a hearing on any revocation of acceptance or denial alleging fraud, misrepresentation or other illegal activity, the insurer or self-insured employer has the burden of proving, by a preponderance of the evidence, such fraud, misrepresentation or other illegal activity * * *."

The portion of ORS 656.262(6)(a) pertaining to "later obtained evidence" provides, in part:

> "If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. * * *"

Although this statutory text does not refer to "materiality," only a material misrepresentation will support a "back-up" denial. *See Ebbtide Enterprises*, 303 Or at 464-65; **<156 Or App 504/505>** *SAIF v. Abbott*, 103 Or App 49, 52-53, 769 P2d 378 (1990); *Newport Elks Club v. Hays*, 92 Or App 604, 607, 759 P2d 327, *rev den* 307 Or 245 (1988). To demonstrate materiality, an insurer need not show that it would, in fact, have denied the claim but for the misrepresentation. *Ebbtide Enterprises*, 303 Or at 464; *Newport Elks Club*, 92 Or App at 607. Rather, the insurer must show that its decision to accept the claim "could reasonably have been affected" if the true facts had been disclosed. *Id.* Thus, the inquiry reduces to a factual determination: In the totality of the circumstances of *this* case, could *this* insurer's acceptance decision "reasonably have been affected" by the undisclosed information? If the Board's resolution of that factual issue is supported by substantial evidence in the record, we must affirm. ORS 183.482(8)(c). *See Ebbtide Enterprises*, 303 Or at 465 ("Because a proper standard for determining materiality was employed and because there is substantial evidence to support these findings, we will not disturb them on review.").

Insurer first contends that the Board employed an erroneous standard of materiality--*viz.* the "but for" standard expressly rejected in *Ebbtide Enterprises*. We disagree. The Board's opinion never employs "but for" language but, instead, twice explicity refers to the correct "could reasonably have been affected" standard.

We further conclude that substantial evidence supports the Board's determination that insurer failed to prove that claimant's misrepresentation "could reasonably have affected" its decision to accept. The "could reasonably have affected" standard necessarily turns on the interplay among at least three considerations: (1) What information did the insurer have at the time of acceptance; (2) what information was concealed or misrepresented; and (3) on what basis did the insurer initially accept the claim. Without knowing why the insurer originally accepted the claim, it is difficult, if not impossible, to assess whether the concealed or misrepresented information could, or might reasonably, have affected that decision.

Here, the insurer, who bore the burden of proof, ORS 656.262(6)(a), offered no evidence or explanation as to why it accepted the claim even though: (a) It knew that claimant **<156 Or App 505/506>** had misrepresented his medical and claims history; (b) it had expressed those concerns to claimant's treating physician; (c) it had requested and was awaiting the records concerning claimant's prior claims, including a back claim; and (d) the statutory time limit for claims acceptance did not expire for another three weeks. Whatever the reasons for the insurer's decision to accept the claim, there is substantial, indeed uncontroverted, evidence that, as the Board found, "the insurer knew *before* it issued its acceptance that claimant was not truthful when he told his treating physicians that he had not previously injured his low back and that he omitted to inform them of the 1990 claim." (Emphasis in original.) Given the totality of the circumstances, the Board did not err in determining that insurer had

not proved that claimant's misrepresentations "could reasonably have affected" its decision to accept the claim. *See, e.g., Ebbtide Enterprises*, 303 Or at 463-65 (substantial evidence supported the Board's determination that the claimant's failure to disclose 1977 low back injury was not material to the insurer's acceptance of July 1982 low back claim, where the claimant had disclosed a February 1982 low back injury and the insurer had failed to follow up *that* disclosure with additional investigation); *Abbott*, 103 Or App at 53 (claimant undercover detective's misrepresentations that his claims were mere "ruses" were not material where ostensible employer "knew what claimant's status at the mill was and that he had filed the claims" but "did not follow up on the claims or take any action to see that they were not sent to [the insurer]").[1]

We affirm the Board's rejection of insurer's "later obtained evidence" argument for similar reasons. As with misrepresentations, later obtained evidence can support a "back-up" denial only if that evidence is material--that is, only if that evidence could reasonably have affected the decision to accept the claim. Again, substantial evidence supports the Board's adverse determination on that issue. We note, moreover, that the alleged later obtained evidence here--**<156 Or App 506/507>** claimant's complete medical records--was evidence that insurer knew of and, in fact, had requested and was awaiting, when it accepted the claim well before the 90-day acceptance period had run. *See CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286, 850 P2d 396 (1993) ("The legislature intended that evidence warranting a retroactive denial 'come about' after the insurer's original acceptance.").

Affirmed.

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[1] The dissent, 156 Or App at 507-08, suggests that our holding permits unscrupulous claimants to sandbag unwary insurers. We disagree. All an insurer has to do to avoid such a result is to show why, given its reasons for accepting the claim, the concealed or misrepresented information could reasonably have affected that decision.

LINDER, J., dissenting.

In my view, this is a very different case from *Ebbtide Enterprises v. Tucker*, 303 Or 459, 738 P2d 194 (1987), and the outcome should be different as well. In *Ebbtide*, the insurer accepted a claim knowing the relevant facts involving the claimant's prior injury to her back and knowing that claimant attributed most of her back problems to a prior 1982 injury. What the insurer did not know was that the claimant previously had injured her back not just in 1982, but also in 1977. The Workers' Compensation Board, in determining whether the insurer's decision "could reasonably have been affected" by knowledge of the prior injury, concluded that there was no reason to believe that the insurer would have investigated further based on the 1977 incident, when the 1982 injury to which most of the back problems were ascribed had not prompted any further inquiry on the insurer's part. *Id.* at 464. The Oregon Supreme Court agreed. *Id.*

Here, insurer was aware in a general way that claimant had made prior claims based on allegedly work-related injuries to his back. Insurer also believed that claimant may have misrepresented his medical history to the examining physician, and insurer therefore wrote the physician to determine if that was the case. At the time of acceptance, insurer was attempting to investigate the prior claims and the full scope of claimant's representations to the examining physician. That state of facts is in marked contrast to the facts in *Ebbtide*, where the insurer had the claimant's acknowledgment of a prior compensable injury to the same body part and undertook no investigation whatsoever on the basis of that prior injury. Insurer here did not have most, or even a significant, share of the essential information or documentation--indeed, it incorrectly thought one prior claim **<156 Or App 507/508>** had been denied, and it did not know the outcome of the other. That claimant's misrepresentation reasonably could bear on the employer's decision is evident, if not by common sense alone, then certainly by the fact that the employer was making reasonable efforts to obtain actual documentation of the prior claims and to confirm with the physician that in fact claimant had not given an accurate medical history.

The majority's real focus seems to be less on the materiality of the misrepresentation and more on the insurer's conduct in accepting the claim prematurely -- that is, with three weeks remaining in which the insurer might have acquired the sought-after documentation and confirmation from the

physician. The insurer's acceptance of the claim at that point may have been inadvertent, negligent, or simply cautious.[1] We do not know. The majority concludes that, without providing an explanation, the insurer could not carry its burden here. 156 Or App at 504-05. That approach turns the policy embodied in ORS 656.262(6)(a) on its head. The statute requires only that the insurer have accepted the claim in good faith. No one disputes that in this case, the insurer did so. Beyond that, the statutory policy places a premium on full and fair disclosure by a claimant. The net effect of the majority's holding in this case is that a claimant may flagrantly misrepresent his or her medical history without consequence if the insurer suspected or had sketchy but undocumented and incomplete information about the misrepresentation, was attempting to obtain more information, and in good faith accepted the claim before the insurer's investigative efforts bore fruit. The statute is seriously disserved by that result. I would reverse.[2]

Accordingly, I dissent.

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[1] An insurer is subject to penalty for unreasonably delaying acceptance or denial of a claim. ORS 656.262(11).

[2] At a minimum, given the majority's determination that an insurer must demonstrate not only its good faith, but "on what basis" the insurer initially accepted the claim, I would remand this case to give the insurer the opportunity to make that demonstration.

Cite as 156 Or App 634 (1998) October 28, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Brian R. Hartman, Claimant,
and In the Matter of the Complying Status of NCE-Deer Lodge Apartments.

NCE-DEER LODGE APARTMENTS, Petitioner,
v.
BRIAN R. HARTMAN; JOHNSTON AND CULBERSON, INC.;
and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(95-04409, 95-04620; CA A93941)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 21, 1997.
Ronald W. Atwood argued the cause and filed the brief for petitioner.
Robert Wollheim argued the cause for respondent Brian R. Hartman. With him on the brief were Welch, Bruun, Green & Wollheim, James C. Egan and Emmons, Kropp, Kryger, et al.
Denise Fjordbeck, Assistant Attorney General, argued the cause for respondents Johnston and Culberson, Inc., and Department of Consumer and Business Services. With her on the brief were Hardy Myers, Attorney General, and Virginia L. Linder, Solicitor General.
David L. Runner filed the brief for respondent SAIF Corporation.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
ARMSTRONG, J.
Affirmed.

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156 Or App 636> Employer seeks review of a decision by the Workers' Compensation Board declaring him to be a noncomplying employer.[1] We review for errors of law, ORS 183.482(7)(a), and affirm.

The facts found by the Board are as follows. Employer is an Oregon landlord who owns a small complex of rental units near Tangent, Oregon, known as the Deer Lodge Apartments. At all relevant times, he employed Nina Fintel as his property manager, paying her $150 per month for her services.

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[1] Employer does not seek review of the Board's conclusion that claimant's injury was compensable.

He also employed claimant, who was a tenant in one of the rental units, to perform general maintenance and property work at the Deer Lodge Apartments and at another property owned by employer. At least once, claimant's wages were used to offset his $200 monthly rent. During one 30-day period, from June 12 to July 11, 1994, claimant and others performed maintenance work and were paid a total labor cost of $480.25 by employer.

On October 12, 1994, claimant slipped and fell while clearing fallen apples from a common lawn that he was preparing to mow. He broke his right tibia and fibula in the fall.

In January 1995, claimant filed a claim for workers' compensation benefits. Employer did not carry workers' compensation insurance for the employees of the Deer Lodge Apartments. The Workers' Compensation Division Compliance Section determined that employer employed one or more subject workers and, therefore, was subject to the Workers' Compensation Law but had not complied with it by carrying workers' compensation insurance for his subject employees. It directed SAIF to process the claim, which SAIF accepted and for which it paid benefits to claimant. Employer requested a hearing, contending that, because claimant's employment was casual and was in the course of the trade, business or profession of a nonsubject employer, claimant was a nonsubject worker. The administrative law judge (ALJ) concluded that, because there had been a single 30-day **<156 Or App 636/637>** period during the course of claimant's employment in which employer's labor costs had exceeded $500, claimant's employment was not casual, and employer was required to provide workers' compensation coverage. On review, the Board adopted and affirmed the ALJ's order.

At issue is the meaning of ORS 656.027, which provides:

> "All workers are subject to this chapter except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(3)(a) A worker whose employment is casual and either:
>
> "(A) The employment is not in the course of the trade, business or profession of the employer; or
>
> "(B) The employment is in the course of the trade, business or profession of a nonsubject employer.
>
> "(b) For the purpose of this subsection, *'casual' refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $500.*"[2]

(Emphasis added.) The specific issue is the proper interpretation of the phrase "any 30-day period." Respondents argue that the text of the statute is clear and unambiguous, requiring any employer whose labor costs have *ever* exceeded $500 *for any given* 30-day period to purchase workers' compensation coverage for any workers still employed after that period, even though the employer's labor costs may never reach $500 again.[3] Employer offers his own interpretation, **<156 Or App 637/638>** which would set the applicable measuring period at the 30 days surrounding the injury.

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[2] Before the 1995 revision of the Workers' Compensation Law, the statutory limit on labor costs was $200. The 1995 revision increased the limit to $500. Because a final order had not been issued in this case before the 1995 revision took effect, the new limit applies. *Volk v. America West Airlines*, 135 Or App 565, 573, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

[3] Although acknowledging that their interpretation cuts a broad swath, respondents contend that employers can avoid a harsh result merely by terminating the employment agreements with those workers and establishing "new" employments to which the previous labor period would not apply. Respondents apparently assume that the situation is likely to occur only in "at-will" employments, where such terminations are possible. We agree with employer that such a solution is absurd, and that the legislature could not have intended for employers to hire and fire workers willy-nilly in order to avoid paying for coverage. Nevertheless, we agree with respondents' interpretation of the statute.

We conclude that, under the plain language of the statute, an employer whose labor costs exceed the statutory limit for at least one 30-day period must provide workers' compensation coverage to its employees, even if its costs never again reach that level. The statute refers to *any* 30-day period and does not require any relationship between the period in which the worker is injured and the 30-day period in which the labor costs exceed the statutory limit. That conclusion is consistent with our interpretation of an earlier version of the statute in *Gordon v. Farrell*, 85 Or App 590, 737 P2d 654, *rev den* 304 Or 55 (1987).[4] In that case, the claimant worked from January to mid-April, for an average of $320 per month. Most of his work then ended. On May 8, the claimant was working on a special job when he was injured. After concluding that the special task was not a significant enough departure from the claimant's usual duties to constitute employment outside the course of trade, business or profession of his employers, we addressed the employers' argument that they were not required to provide workers' compensation coverage, because their labor costs for the 30-day period preceding the injury did not exceed the statutory limit. *Id.* at 594. We concluded that, because the evidence showed that the employer had *in the past* exceeded the statutory minimum, the statutory requirement had been met and the casual employment exemption did not apply. *Id.*; *cf. Konell v. Konell*, 48 Or App 551, 617 P2d 313 (1980), *rev den* 290 Or 449 (1981) (no evidence that employer had ever met the statutory minimum).

With that in mind, we turn to the facts of this case. The evidence before the Board was that employer's payroll for the Deer Lodge Apartments included Nina Fintel and claimant. Claimant was assisted on occasion by friends, who were paid out of claimant's earnings. Nina Fintel was paid $150 per month. Claimant's monthly earnings varied from month to month. In June 1994, claimant's wages for the work **<156 Or App 638/639>** he typically performed were $191. In July 1994, he earned $131. From June 18 to 29, 1994, claimant and two helpers performed additional work, however, repairing a mobile home from which a tenant had been evicted. That additional labor, at a cost of $250, when combined with claimant's other earnings and Fintel's wage, drove employer's labor costs for the 30-day period of June 12 to July 11 over the statutory minimum of $500. Accordingly, employer no longer qualified for the casual worker exemption to the requirement that it provide workers' compensation coverage for its employees, and the Board correctly upheld employer's designation as a non-complying employer.

Affirmed.

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[4] The only relevant difference between the current version of ORS 656.027(3)(b) and the version that was in effect in 1987 is that the statutory limit for the casual employment exemption in 1987 was $200.

Cite as 157 Or App 125 (1998) November 4, 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.
On petitioner's Petition for Reconsideration filed September 16, 1998.
Opinion filed September 2, 1998. 155 Or App 601, ___ P2d ___.
Charles M. Fryer for the petition.
Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Reconsideration allowed; opinion modified and adhered to as modified.

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157 Or App 127> Petitioner seeks reconsideration of our decision in *Coghill v. Natl. Council on Comp. Ins.*, 155 Or App 601, ___ P2d ___ (1998),[1] in which we upheld a determination that petitioner was required to provide workers' compensation coverage for certain siding installers in his employ. Petitioner contends that we made a factual error when we stated that "[t]he record before us does not show that installers worked with or for any other parties during the audit period." We agree with petitioner that there is information in the record to support a finding that the installers worked for other people during the audit period. Hence, we modify our earlier opinion to delete the quoted sentence. The deletion of the sentence does not change the reasoning on which we relied to uphold the agency's decision, and we adhere to our opinion as modified.

Reconsideration allowed; opinion modified and adhered to as modified.

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[1] Petitioner also seeks reconsideration in a companion case, *Coghill v. Natl. Council on Comp. Ins.*, 155 Or App 638, ___ P2d ___ (1998). We have denied that petition by order of this date.

Cite as 157 Or App 128 (1998) November 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROBERT H. BAUGH, Appellant,

v.

MAINTENANCE AND MACHINE ERECTORS, INC., an Oregon corporation, Respondent.

(96-CV-0298-ST; CA A98634)

Appeal from Circuit Court, Deschutes County.

Stephen N. Tiktin, Judge.

Argued and submitted May 11, 1998.

Steven D. Bryant argued the cause for appellant. With him on the brief was Bryant, Emerson & Fitch.

Thomas M. Christ argued the cause for respondent. With him on the brief was Mitchell, Lang & Smith.

Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.

LINDER, J.

Affirmed.

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157 Or App 130> Plaintiff brought this tort action seeking to hold defendant liable for injuries that plaintiff sustained on the job. The sole issue on appeal is whether defendant is immune from tort liability under ORS 656.018(4) (1993) as a client of a worker leasing company. Under the parties' arguments, that issue turns chiefly on whether plaintiff was employed on a temporary or permanent basis.[1] The trial court granted summary judgment for defendant, concluding that the record was insufficient to permit a factfinder to determine that plaintiff was employed on a temporary basis and that defendant therefore was immune as a matter of law. We affirm.

For the most part, the facts are not disputed. Defendant, Maintenance and Machine Erectors, Inc. (MME), is a metal fabrication and construction company. MME obtains most of its workers through Mid-Oregon Labor Contractors, Inc. (Mid-Oregon). At the time plaintiff was injured, Mid-Oregon was a worker leasing company, licensed as such by the Department of Consumer and Business Services (DCBS) under ORS 656.850 (1993). In early 1995, plaintiff, a journeyman welder, interviewed with Nelson Howard, MME's owner and president, for a position with MME. During the interview, they discussed an airport tower project bid that MME anticipated winning and for which plaintiff's skills appeared well-suited. Howard decided he was willing to put plaintiff to work on the project, if MME got it, and that until then, plaintiff could work on other projects "around [MME's] shop." At the end of the interview, Howard told plaintiff that MME obtained all of its workers through Mid-Oregon. Howard therefore directed plaintiff to Mid-Oregon to fill out an application. Mid-Oregon hired plaintiff to work at MME's plant beginning February 6, 1995, and put him to work before **<157 Or App 130/131>** MME knew whether it would receive the airport bid. Shortly after beginning the position, plaintiff suffered a back injury while working on a project for MME. Plaintiff sought and recovered workers' compensation benefits (except for vocational assistance) through Mid-Oregon's insurer. He then brought this tort claim against MME, seeking to obtain further recovery for his back injury.

In its summary judgment motion, MME, as the moving party, had the burden of demonstrating that there were "no genuine issues of material fact" and that it was "entitled to judgment as a matter of law." *See Jones v. General Motors Corp.*, 325 Or 404, 420, 939 P2d 608 (1997) (quoting *Seeborg v. General Motors Corporation*, 284 Or 695, 699, 588 P2d 1100 (1978)). On appeal, we view the record in the light most favorable to plaintiff, the nonmoving party. *Id.* The only significant factual dispute regards the terms on which plaintiff was hired. Plaintiff stated that he was told that he was hired on a "temporary" basis, with the understanding that if "things worked out" he might be kept permanently. That meant, plaintiff explained, that if he could back up his resume and perform the work that he told them he was

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[1] Defendant argues for the first time on appeal that, if ORS 656.018(4) (1993) does not immunize it from tort liability, then subsection (1)(a) does. In the temporary services area, we have determined that both the temporary services agency and the client may be employers, in which case, if either employer provides workers' compensation coverage, both are immune. *See, e.g., Perry v. Express Services, Inc.*, 143 Or App 321, 325, 923 P2d 673 (1996), *rev den* 324 Or 560 (1997). Because we affirm based on the argument presented to the trial court, we do not decide whether we should reach the subsection (1)(a) argument despite the lack of preservation.

capable of performing, he would continue with MME indefinitely. Mid-Oregon asserted that it hired plaintiff to fill an available full-time, permanent position. Plaintiff focuses on that factual dispute because, in his view, if he was a "temporary" employee, MME cannot claim immunity as a client of a worker leasing company. Plaintiff contends that his deposition testimony on the point is sufficient to create a material issue of fact precluding summary judgment.

Employees injured on the job are usually limited to workers' compensation benefits as their exclusive remedy. The workers' compensation statute immunizes complying employers from common law liability for work-related injuries. *See generally* ORS 656.018 (1993). That general immunity extends to "worker leasing companies" and their clients through ORS 656.018(4) (1993),[2] which provides:

> **157 Or App 132>** "The exemption from liability given an employer under this section applies both to a worker leasing company and the client to whom workers are provided when the worker leasing company and the client comply with ORS 656.850(3)."

Plaintiff's argument against MME's claim of tort immunity is premised on ORS 656.850(1) (1993), which defines "worker leasing company" as

> "a person who provides workers, by contract and for a fee, to work for a client *but does not include a person who provides workers to a client on a temporary basis to supplement the existing work force in special situations* such as employee absences, professional skill shortages, seasonal workloads and special assignments and projects with the expectation that the position or positions will be terminated upon completion of the special situation."

(Emphasis added.) The assumption that underlies plaintiff's argument is that whether a leased worker is permanent or temporary--and thus, whether MME enjoys immunity--hinges only on a fact-bound inquiry into the particular terms on which an individual employee was hired and put to work for the client. Under the pertinent statutes and implementing regulations,[3] however, that is only part of the inquiry.

ORS 656.855 charges the director of DCBS with the task of establishing a licensing system for worker leasing companies. As part of that charge, the director is authorized to prescribe the form and contents of records that a licensee **<157 Or App 132/133>** must maintain. ORS 656.855(1)(d) (1993). Primarily, the rules require worker leasing companies to file written notice when they provide leased workers to a particular client and to ensure workers' compensation coverage for those leased workers. OAR 436-050-0410(1) and OAR 436-050-0400(1)-(2).

Anticipating the complications that may arise in distinguishing "temporary workers" from "leased workers," the director specially promulgated rules for that purpose. OAR 436-050-0420(1), which was in effect at the time of plaintiff's injury, states:

> "A person who provides a worker to work for a client will be considered to be providing the worker on a 'temporary basis' *only if* there is a contemporaneous written documentation, retained by either the client or the temporary service provider, which indicates the duration of the work performed *and* the worker is provided under one or more of the following conditions: * * *"

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[2] Plaintiff was injured in February 1995. Portions of the relevant statutes were amended in both 1995 and 1997. Therefore, we quote only from the 1993 version of the statutes.

We note that the 1997 amendments resolve disputes of this kind for cases arising after their effective date. ORS 656.018(5)(a) (1997) states that the "exemption from liability given an employer under this section applies to a temporary service provider, as that term is used in ORS 656.850, and also extends to the client to whom workers are provided when the temporary service provider complies with ORS 656.017." Thus, under the 1997 version of the statute, MME would be immune even if plaintiff's employment was on a temporary basis.

[3] The policies of providing workers' compensation coverage for subject workers and immunity for complying employers are necessarily parallel and complimentary. The administrative rules bearing on who is a subject worker and the compliance obligations of employers therefore must be considered in a tort case in which ORS 656.018(4) (1993) is raised in defense. The director's rules are not absolutely "binding," in the sense that if the rules are beyond the director's authority or otherwise vulnerable to challenge, the court can so hold in a case such as this. *See Alto v. State Fire Marshall*, 319 Or 382, 390-91, 876 P2d 774 (1994); *Hay v. Dept. of Transportation*, 301 Or 129, 136, 719 P2d 860 (1986). But absent a proper collateral challenge to the rules, they should be given full effect in resolving the immunity dispute.

(Emphasis added.) The rule then specifies circumstances in which a properly documented work arrangement will be deemed to be on a "temporary basis"--*i.e.*, to replace a worker who is gone on temporary leave for a determinate period of time; to staff a seasonal workload; or to fill a professional skill shortfall. OAR 436-050-0420(1)(a)-(f). The director further has decided by rule that as long as any workers provided by contract and for a fee are not provided on a "temporary basis," the person furnishing the workers will be considered a worker leasing company. OAR 436-050-0420(2). Moreover, if a worker leasing company provides both leased workers and workers on a temporary basis, it must also maintain payroll records that show specifically which workers are provided on a temporary basis, thus clearly differentiating between the "leased" and the "temporary workers." OAR 436-050-0420(3).

In effect, then, all workers of licensed worker leasing companies are presumed to be leased workers; to overcome that presumption, worker leasing companies must take affirmative steps to document "temporary" status at the time a worker is provided to the client. They must also distinguish between "leased" and "temporary" workers in their payroll records. The director's rules serve to resolve doubts in favor of **<157 Or App 133/134>** deeming a business to be a worker leasing company rather than a temporary service provider and deeming workers provided by a worker leasing company to be leased rather than temporary workers.

Here, the parties do not dispute that Mid-Oregon had jumped through all regulatory hoops necessary to be a properly licensed and complying worker leasing company. It obtained a worker leasing company license from DCBS. It complied with OAR 436-050-0410(1) by notifying DCBS that it was providing leased workers to MME and submitting proof of workers' compensation coverage. It, in fact, met its obligations under ORS 656.017 and 656.407 (1993) to provide workers' compensation insurance for all workers supplied to MME, and plaintiff received the benefit of it having done so.[4] Mid-Oregon did not avail itself of the procedures to designate plaintiff as a temporary worker. For Mid-Oregon to do that, not only would it have had to hire plaintiff on a "temporary basis" within the meaning of the statute, but in addition, Mid-Oregon would have had to take affirmative steps to document plaintiff as a temporary worker and distinguish between "leased" and "temporary workers" in its payroll records. It did neither. Plaintiff has not pointed to any contemporaneously written documentation indicating the duration of the work to be performed by plaintiff. Nor did Mid-Oregon clearly distinguish leased workers from temporary workers or distinguish plaintiff from all other workers provided by Mid-Oregon, as OAR 436-050-0420(3) would require.[5]

157 Or App 135> Thus, the terms of plaintiff's employment agreement with Mid-Oregon are not dispositive. Those terms would matter only if Mid-Oregon had sought to take advantage of the "temporary basis" exception in ORS 656.850 (1993) to avoid the requirement to provide workers compensation insurance for plaintiff. Therefore, any factual dispute on that point was not material and did not preclude summary judgment. Accordingly, we hold that defendant is entitled to the immunity provided by ORS 656.018(4) (1993).

Affirmed.

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[4] Plaintiff relies on the fact that Mid-Oregon's insurer, in the processing of the workers' compensation claim, successfully denied him vocational assistance on the basis of his "temporary" status. As our analysis demonstrates, that fact is not relevant to the question of MME's immunity as Mid-Oregon's client. But it is worth pointing out that plaintiff's argument in that regard demonstrates the problems with using the labels "permanent," "leased," and "temporary." ORS 656.850(1) (1993) distinguishes between leased workers and those provided on a temporary basis. On the other hand, OAR 436-120-0310, the administrative rule on which the insurer relied to deny plaintiff's vocational assistance eligibility, distinguishes only between "permanent, year-round employment" and "other" jobs. See OAR 436-120-0310(1)(g), (3), and (6). Neither the terminology nor the concepts behind it are the same. Thus, the fact that a worker is employed on something other than permanent, year-round basis does not answer--at least not necessarily--whether the worker is employed on a temporary basis.

[5] Plaintiff argues that he should be considered a temporary worker because he was listed on MME's records as a "TEMP MILLWRIGHT." That designation does not aid plaintiff, however, because it did not satisfy the director's rule. Before plaintiff began work at MME, Mid-Oregon had described all the workers only as "MILLWRIGHT" in its bills to MME. Beginning with the first bill that included plaintiff's services, Mid-Oregon described all the workers as "TEMP MILLWRIGHT," including those who had worked for MME under the prior label. Thus, the payroll billings made no distinction between the temporary and leased workers at MME, contrary to what the rule requires. Therefore, under the rule, all of the workers, including plaintiff, must be deemed to be leased workers.

Cite as 157 Or App 147 (1998) November 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ronald E. Rogers, Claimant.

REYNOLDS METALS and CIGNA INSURANCE COMPANY, Petitioners - Cross-Respondents,
v.
RONALD E. ROGERS, Respondent, and LIBERTY MUTUAL INSURANCE CO., Respondent - Cross-Petitioner.
(93-11544, 94-14661, 95-01825; CA A96634)

Judicial Review from the Workers' Compensation Board.

Argued and submitted June 3, 1998.

Montgomery W. Cobb argued the cause and filed the briefs for petitioners - cross-respondents Reynolds Metals and Cigna Insurance Company.

Meagan A. Flynn argued the cause for respondent Ronald E. Rogers. With her on the briefs was Pozzi Wilson Atchison, LLP.

Alexander Libmann argued the cause for respondent - cross-petitioner Liberty Mutual Insurance Co.

Before Riggs, Presiding Judge pro tempore, and Landau and Wollheim, Judges.

WOLLHEIM, J.

Reversed and remanded for reconsideration on the petition; affirmed on the cross-petition.

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157 Or App 149> Cigna Insurance Co. (Cigna), on behalf of its insured Reynolds Metals, seeks review of a Workers' Compensation Board (Board) order assigning it responsibility for claimant's right shoulder condition. Liberty Mutual (Liberty), which insured Reynolds Metals prior to Cigna, cross-petitions seeking review of the Board's order assessing a penalty and attorney fees. We review for substantial evidence and errors of law. ORS 183.482(8), 656.298(7). We affirm in part and reverse in part on the petition and affirm on the cross-petition.

Claimant began working for Reynolds Metals in 1967 and stopped working there in November 1991. In 1979, while Liberty insured employer, claimant sought medical treatment from Dr. Manley for right shoulder pain. In a letter to Liberty, Manley diagnosed claimant's condition as degenerative osteoarthritis of the right shoulder joint.[1] Manley wrote that the condition was due to claimant's work. Liberty responded by returning the billings for the right shoulder treatment, stating that no claim had been made for the right shoulder. Manley replied, stating that claimant had sustained a new injury, and that his opinion remained that claimant's shoulder condition was work related. Liberty did not process Manley's request for payment as a workers' compensation claim.

Claimant continued working for Reynolds Metals, and he periodically complained of right shoulder ailments. In May 1990, claimant had a sudden onset of right shoulder pain and sought medical treatment. Cigna, employer's new insurer, accepted the claim as a disabling injury but did not specify what condition it accepted. In 1993, claimant again had a sudden onset of right shoulder pain and sought medical treatment. Manley requested authorization from Cigna for right shoulder surgery. In September 1993, Cigna denied that claimant's May 1990 injury was either the material or major cause of the proposed surgery. During a deposition of **<157 Or App 149/150>** Manley, Cigna and claimant first learned of the 1979 correspondence between Manley and Liberty. Based on this information, Cigna issued a second denial of compensability and also disclaimed responsibility for the right shoulder condition. Claimant then filed a hearing request against Liberty, alleging a *de facto* denial of the 1979 claim. In response, Liberty formally denied compensability and disclaimed responsibility for claimant's right shoulder condition. The Administrative Law Judge (ALJ) set aside both compensability denials, assessed attorney fees against *both* insurers for setting aside the denials, found Cigna responsible, and assessed a penalty against Liberty for its unreasonable processing of the 1979 claim. The Board affirmed.

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[1] Manley provided a copy of the letter to employer's on-site physician. Thus, employer also had knowledge of the 1979 medical treatment.

Both Cigna and Liberty argue that the Board erred in not dismissing the right shoulder claim because it was not timely filed with Liberty and because there was no timely request for a hearing. In addition, Cigna argues that the Board erred in assigning it responsibility for claimant's right shoulder condition. Liberty argues that the Board erred in assessing a penalty and attorney fees against it.

We first address the insurers' contention that the claim was not timely filed. In 1979, an occupational disease claim had to be filed within 180 days from the date a worker became disabled or was informed by a physician that he was suffering from an occupational disease. ORS 656.807(1) (1979).[2] Both insurers argue that no claim was filed with Liberty until 1994 and that claimant's 1994 request for a hearing was also untimely. In support of that argument, insurers rely on ORS 12.010 and 12.140. ORS 12.010 provides:

> "Actions shall only be commenced within the periods prescribed in this chapter, after the cause of action shall have accrued, except where a different limitation is prescribed by statute."

ORS 12.140 provides:

> **157 Or App 151>** "An action for any cause not otherwise provided for shall be commenced within 10 years."

Relying on those statutes, insurers argue that claimant failed to timely request a hearing on Liberty's *de facto* denial. We disagree.

Dr. Manley's submission of medical records and his billing constituted a workers' compensation claim. A claim is any written request for compensation tendered by the injured worker or by someone else on the worker's behalf. ORS 656.005(6). *See also Safeway Stores, Inc. v. Smith*, 117 Or App 224, 227, 843 P2d 1000 (1992) (a physician's report requesting medical treatment for a specified condition constitutes a claim). Thus, a claim for compensation was timely filed with Liberty and with Reynolds Metals when each received Manley's records and reports. The fact that neither Liberty nor Reynolds Metals processed the 1979 claim does not mean that the claim was not timely filed.

Insurers' argument is further deflated by the fact that ORS 12.140 does not apply to workers' compensation claims. Instead, the Workers' Compensation Act is the "complete statement of the parties' rights and obligations, and they are *sui generis*." *Haret v. SAIF*, 72 Or App 668, 674, 697 P2d 201, *rev den* 299 Or 313 (1985). ORS 12.140 states that an *action* must be commenced within 10 years. ORS 12.020(1) provides that an action is commenced when a complaint is filed and summons served on a defendant. *See also* ORCP 3 (*action* is commenced by the filing of a complaint with the clerk of the court). In contrast, a workers' compensation claim is not an action. No complaint is ever filed with the clerk of the court when a workers' compensation claim is made. Rather, a notice of a claim is filed with the employer. ORS 656.265(1). There is no service of a summons on the "defendant" because there is no defendant in a workers' compensation case. Accordingly, claimant's 1994 request for hearing, alleging a *de facto* denial, was timely because Liberty had not issued a written denial. *Bebout v. SAIF*, 22 Or App 1, 5-6 n 1, 537 P2d 563, *aff'd* 273 Or 487 (1975) (insurer has an obligation to formally deny a claim when they have actual knowledge of it). While there is a time limitation to file a request for hearing on a written denial, ORS 656.319(1), **<157 Or App 151/152>** there is no similar time limitation to file a request for hearing on a *de facto* denial. ORS 656.283(1)[3] provides that a party can file a request for hearing at any time on any matter concerning a claim.

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[2] At that time, ORS 656.807(1) (1979) provided, in part:

> "All occupational disease claims shall be void unless a claim is filed * * * within 180 days from the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease."

[3] ORS 656.283(1) provides, in part:

> "Subject to ORS 656.319, any party * * * may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245, 656.248, 656.260, 656.327 and subsection (2) of this section."

Next, Cigna argues that the Board erred in assigning it responsibility for claimant's right shoulder condition because ORS 656.308(1) relieves an employer of responsibility when the employee is injured again. That statute provides, in part:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

Cigna argues that because the Board found that claimant sustained a compensable injury in 1979, while Liberty insured employer, Liberty remains responsible for claimant's condition. We disagree. ORS 656.308(1) does not apply in this situation. The statute applies only where there is a previously accepted compensable injury. In *SAIF v. Yokum*, 132 Or App 18, 23, 887 P2d 380 (1994), we held:

> "On its face, [ORS 656.308(1)] addresses the issue of when a responsible employer can shift responsibility to a subsequent employer. It begins from the premise that there is an employer that is responsible to pay for a particular compensable condition. There is no responsible employer until there is an accepted claim and a determination of responsibility, if there is more than one potentially responsible employer. Thus, for the statute to be triggered, there must be an accepted claim for the condition, for which some employer is responsible. In an initial claim context, no employer is responsible until responsibility is fixed."

See also Norstadt v. Murphy Plywood, 148 Or App 484, 493, 941 P2d 1030, *on recons* 150 Or App 245, 945 P2d 654 (1997), **<157 Or App 152/153>** *rev den* 327 Or 432 (1998) (ORS 656.308(1) is limited to claims involving previously processed claims).

Cigna also argues that the Board improperly assigned it responsibility under the last injurious exposure rule (LIER). There are, at least, two aspects of LIER: (1) proof of a compensable claim, and (2) assignment of liability between insurers. *Bracke v. Baza'r*, 293 Or 239, 245, 646 P2d 1330 (1982). LIER allows the injured worker to establish compensability based on all employment-related exposure without proving causation against any particular employer or insurer. Once it is established that a condition is work related, the rule assigns initial responsibility to the last period of employment whose conditions might have caused the disability. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244, 675 P2d 1044 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke*, 293 Or at 248. If the injured worker receives medical treatment before experiencing time loss due to the condition, then the date of first medical treatment is determinative for assigning initial responsibility for the claim. *Timm v. Maley*, 125 Or App 396, 401, 865 P2d 1315 (1993), *rev den* 319 Or 81 (1994). The last insurer can transfer liability to a previous insurer by establishing that it was impossible for its employer to have caused the condition or that a prior period of employment was the sole cause of the condition. *Roseberg Forest Products v. Lang*, 325 Or 305, 313, 937 P2d 517 (1997). Alternatively, the initially responsible insurer can transfer liability to a subsequent insurer by establishing that the subsequent employment actually contributed to a worsening of the condition. *Oregon Boiler Works v. Lott*, 115 Or App 70, 74, 836 P2d 756 (1992). However, in order to shift responsibility to a subsequent insurer, the injured worker must suffer a worsening of the condition; a mere increase in symptoms is not sufficient. *Boise Cascade*, 296 Or at 243; *Timm v. Maley*, 134 Or App 245, 249, 894 P2d 1245 (1995); *Oregon Boiler Works*, 115 Or App at 74.[4]

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[4] We recognize the apparent inconsistency concerning LIER. The rule does not always assign liability to the last employer or insurer. The operation of the rule is "somewhat arbitrary." *Bracke*, 293 Or at 249. The rule is still useful, and its application consistent. Any employer can prove that its work environment could not possibly have been the cause of the condition or that the condition was caused solely by a prior period of employment. Thus, the last employer can shift responsibility backwards. Likewise, an employer who is initially assigned responsibility based on the "onset of disability" can shift responsibly forward by establishing that a subsequent period of employment caused a worsening of the injured worker's condition.

157 Or App 154> Claimant first sought medical treatment in 1979, while Liberty insured Reynolds Metals. Therefore, initial responsibility is assigned to Liberty. In order to shift responsibility to Cigna, there must be evidence that claimant's condition worsened while Cigna insured Reynolds Metals. The problem is that neither the ALJ nor the Board determined whether the medical evidence established that claimant's shoulder condition worsened. Rather, the ALJ and the Board applied the test discussed in *Beneficiaries of Strametz v. Spectrum Motorwerks*, 135 Or App 67, 74, 897 P2d 335, *mod* 138 Or App 9, 906 P2d 825 (1995). The Supreme Court subsequently reversed our decision in *Strametz*. 325 Or 439, 939 P2d 617 (1997). Accordingly, it is necessary to remand this case to the Board for reconsideration under the correct standard and such proceedings as the Board deems necessary.[5]

We turn next to Liberty's cross-petition for review. Liberty argues that the Board erred in assessing a penalty under ORS 656.262(11) for unreasonable claim processing. Liberty argues that ORS 656.319(6) bars a claim for unreasonable claim processing that is more than two years after the fact. ORS 656.319(6) provides:

> "A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

That language was enacted by the 1995 legislature. Or Laws 1995, ch 332, section 39. Generally, the 1995 amendments to the Workers' Compensation Act were retroactive. *Volk v. America West Airlines*, 135 Or App 565, 572-73, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). However, there are exceptions to the retroactive effect of the 1995 amendments. Oregon Laws 1995, chapter 332, section 66(6) provides:

> **157 Or App 155>** "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."

The requests for hearing filed on Liberty's denials were filed before the effective date of ORS 656.319(6). At the time of filing, there was no time limitation on requesting a hearing concerning a penalty before the enactment of ORS 656.319(6). Accordingly, it follows that ORS 656.319(6) shortened a procedural time limit and, thus, cannot apply retroactively. *See Boone v. Wright*, 314 Or 135, 141, 836 P2d 727 (1992) (a statute that shortens a limitation period applies prospectively if the legislature does not clearly express a contrary intent). The Board correctly held that ORS 656.319(6) does not apply to this case. We agree with the Board that Liberty and Reynolds Metals acted unreasonably in processing the 1979 claim.

Liberty's final assignment concerns the assessment of attorney fees under ORS 656.386(1). Liberty concedes that if the 1979 claim was timely then the award of attorney fees was proper. Because we conclude that the Liberty claim was timely, we affirm the award of attorney fees for prevailing on Liberty's compensability denial.

Reversed and remanded for reconsideration on the petition; affirmed on the cross-petition.

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[5] There is medical evidence from Manley in the record that claimant's condition worsened while Cigna insured employer. However, there is also medical evidence in the record indicating that claimant's condition had not worsened. The Board must resolve this dispute in the first instance.

Cite as 157 Or App 184 (1998) November 4, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Karen L. Gallimore, Claimant.

LABOR READY, INC., Petitioner,
v.
KAREN L. GALLIMORE, Respondent.
(96-07968; CA A100462)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 30, 1998.
Ridgway K. Foley, Jr., argued the cause for petitioner. With him on the brief were Greene & Markley, P.C., Ridgway K. Foley, Jr., P.C., Scott F. Gilman, and Breathouwer & Gilman.
Robert W. Pardington argued the cause for respondent. With him on the brief was Pozzi Wilson Atchison LLP.
Before De Muniz, Presiding Judge, and Deits, Chief Judge, and Linder, Judge.
PER CURIAM
Affirmed. *SAIF v. Falconer*, 154 Or App 511, 963 P2d 50 (1998).
De Muniz, P. J., dissenting.

DE MUNIZ, P. J., dissenting.

157 Or App 185> In *SAIF v. Falconer*, 154 Or App 511, 963 P2d 50 (1998), this court held that a stiff neck is compensable as a mental disorder under ORS 656.802, the occupational disease law. I dissented in Falconer because there was no evidence that the medical or psychological community recognizes a stiff neck as a mental disorder, as required by ORS 656.802(3)(c).

Here, the majority now holds, on the basis of *Falconer*, that a herniated disc is a mental disorder. That is an extraordinary conclusion. For the reasons I dissented in Falconer, I dissent here.

Cite as 157 Or App 199 (1998) November 18, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard Rivera, Claimant.

RICHARD RIVERA, Petitioner,
v.
CITY OF GRESHAM, Respondent.
(WCB No. 95-04359; CA A99751)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 10, 1998.
Victor Calzaretta argued the cause and filed the brief for petitioner.
Richard D. Barber, Jr., argued the cause for respondent. With him on the brief was Sheridan & Bronstein.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
LANDAU, P. J.
Reversed and remanded for reconsideration.

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157 Or App 201> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's denial of his claim for post traumatic stress disorder (PTSD). Among other things, he contends that the board erred in concluding that he failed to establish the compensability of his claim, because the board improperly required him to satisfy certain diagnostic criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed 1994) (DSM-IV) without expert testimony as to the applicability of those criteria. We agree and reverse and remand for reconsideration.

It is not necessary to state the relevant facts in detail to resolve the dispositive issue on review. Claimant is a police officer. He filed a claim for PTSD, which he contends he suffers as a result of an on-the-job incident in which he shot and killed a suspect. Employer denied the claim. At the hearing, the medical evidence conflicted. Two physicians offered the opinion that claimant suffers from PTSD as a result of the shooting incident. Two physicians expressed the opinion that claimant's symptoms do not reflect PTSD and that he is using the claim for secondary gain. Several of the physicians mentioned the DSM-IV, but none testified that the diagnostic criteria expressed therein must be satisfied for claimant properly to be diagnosed as suffering from PTSD.

The Administrative Law Judge (ALJ) affirmed the denial of the claim. The ALJ reasoned that "PTSD cannot be diagnosed unless the criteria contained in DSM-IV 309.81 [relating to PTSD] are satisfied." The ALJ then analyzed the evidence offered at the hearing to determine whether claimant had satisfied all of the required criteria. Finding that claimant had failed to do so, the ALJ concluded that claimant had not established that he suffered from PTSD. The Board adopted the ALJ's findings and conclusions, with the exception of several specific sentences not pertinent to the disposition of the case on review.

Claimant now argues that the board erred in basing its decision on his failure to satisfy diagnostic criteria in the DSM-IV, because there was no evidence offered as to the applicability of those diagnostic criteria. Employer argues **<157 Or App 201/202>** that the board's reference to the DSM-IV was not improper, because it was not used as evidence. Rather, employer argues, it was "a sort of 'infrastructure'" on which the board examined the evidence for the presence of a mental or emotional disorder.

ORS 656.802(3) provides, in part:

> "Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:
>
> "* * * * *

> "(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community."

In determining the extent to which a claimant has established the required diagnosis, the board is limited to the evidence in the record. ORS 656.268(7)(g). When confronted with terms of art, the board may be entitled to consult reference works to the extent that the information in them otherwise would be subject to judicial notice. *SAIF v. Calder*, 157 Or App 224, ___, P2d ___ (1998). But, as the Supreme Court has cautioned, in advice to judges that is equally applicable to the board,

> "self-restraint must be exercised in order to avoid the taking of evidence from a source not subject to confrontation and cross-examination. * * * This is not to say that * * * judges cannot resort to outside reading in order better to understand the evidence, but the judge must be ever conscious that the material read is not to be considered as evidence itself unless the material is a proper subject of judicial notice."

Bend Millwork v. Dept. of Revenue, 285 Or 577, 584, 592 P2d 986 (1979); *see also Creasey v. Hogan*, 292 Or 154, 169, 637 P2d 114 (1981).

In this case, the board held that "PTSD cannot be diagnosed unless the criteria contained in DSM-IV 309.81 are satisfied." Whether we may properly characterize it as a finding of fact or a description of "infrastructure," we are unable to find any basis for the board's statement. No statute or administrative rule adopts the DSM-IV criteria as the *sine* **<157 Or App 202/213>** *qua non* of a PTSD diagnosis. No one testified that those criteria are required either. No one suggests that the necessity of satisfying each of the diagnostic criteria is the proper subject of judicial notice. Indeed, the DSM-IV itself appears to caution against just such a use of its diagnostic criteria:

> "It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe."

DSM-IV at xxiii. We conclude therefore that, on this record, the board erred in holding that each of the DSM-IV diagnostic criteria must be satisfied to establish that claimant suffers from PTSD.

Employer argues that, in any event, there is more than adequate evidence to support the board's ultimate finding that claimant failed to establish the compensability of his claim. That may well be the case. It is not possible, however, for us to determine whether the result would have been different had the board not, in effect, made its own diagnosis of claimant's condition on the basis of its reading of the DSM-IV. We therefore reverse and remand the case for reconsideration. *Calder*, 157 Or App at 228.

Reversed and remanded for reconsideration.

Cite as 157 Or App 224 (1998) November 18, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of George B. Calder, Claimant.

SAIF CORPORATION and WALLACE BUICK JEEP EAGLE, Petitioners,
v.
GEORGE B. CALDER, Respondent.
(95-12587; CA A98273)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 17, 1998.
Julene M. Quinn argued the cause for petitioners. On the brief was Michael O. Whitty.
Edward J. Harri argued the cause for respondent. With him on the brief were J. David Kryger and Emmons, Kropp, Kryger, Alexander, Egan and Elmer, P. C.
Before Riggs, Presiding Judge pro tempore, and Landau and Haselton, Judges.
RIGGS, P. J. pro tempore.
Reversed and remanded for reconsideration.

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157 Or App 226> SAIF seeks review of an order of the Workers' Compensation Board, affirming without opinion an order of the Administrative Law Judge (ALJ) holding that claimant has a rateable scheduled disability of the right arm. Because we agree with SAIF that the medical evidence does not support the Board's finding that claimant has disability to the arm, we reverse and remand the case for reconsideration of the award.

Claimant injured his right shoulder at work when he slipped and fell on some ice. Claimant's physician diagnosed a rotator cuff tear and recommended surgery. SAIF accepted a claim for strain and right rotator cuff tear. After claimant was determined to be medically stationary, Dr. Vigeland, claimant's treating physician, reported to SAIF that 100 percent of claimant's loss resulted from loss of muscle or disruption of the musculotendinous unit in the right rotator cuff. In his operative report he noted that the coracobrachialis ligament was preserved during surgery.

SAIF closed the claim with an award of 35 percent unscheduled disability for the right shoulder. Claimant requested reconsideration, disagreeing with the medical impairment findings and requesting an award of scheduled disability and an increase in unscheduled disability.

A medical arbiter, Dr. Scheinberg, examined claimant, and reported:

> "Motor strength in the upper extremities *in the shoulder flexors is 3/5 on the right, 5/5 left.* Shoulder abductors are 3/5 on the right, 5/5 left. External rotators are 3/5 right, 5/5 left. Extensors are 5/5 bilaterally. Internal rotators are 5/5 bilaterally. Biceps, triceps, and wrist strength is all 5/5 bilaterally. Intrinsics are normal, pinch is normal. Grip strength is 80 foot pounds on the right, 90 pounds left.
>
> **"IMPRESSION:**
>
> "1. Chronic tear, right rotator cuff, and long head of right biceps tendon, superimposed on degenerative arthritic changes in the subacromial space." (Emphasis added.)

157 Or App 227> Following receipt of Scheinberg's report, the Appellate Unit issued an order on reconsideration reducing claimant's unscheduled award to 31 percent but awarding scheduled disability for a 13 percent loss of strength in the right arm.

The Board accepted Scheinberg's opinion that claimant had suffered loss of strength in the right shoulder flexors. It determined, by reference to a medical dictionary, that claimant's coracobrachial ligament, which had been mentioned in Vigeland's operative report as having been "preserved" during surgery, was a ligament of the arm involved in shoulder flexion. The Board then found that claimant had suffered loss of strength in the right arm.

SAIF challenges only the scheduled award for the right arm, asserting that it is not supported by the medical evidence. The question is whether, in its interpretation of the medical reports, the Board could reasonably find that the coracobrachial ligament was involved and that claimant had suffered loss of strength in the right arm.

A court or administrative agency may take judicial notice of facts "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." OEC 201 (b)(2); ORS 183.450(4). A dictionary may be such a "source." *See Bend Millwork v. Dept. of Revenue*, 285 Or 577, 592 P2d 486 (1979). We and the Supreme Court have often referred to medical dictionaries to define medical terms. *See, e.g., Barrett v. Coast Range Plywood*, 294 Or 641, 643, 661 P2d 926 (1983); *Robinson v. SAIF Corp.*, 147 Or App 157, 159, 935 P2d 454 (1997); *Gornick v. SAIF Corp.*, 92 Or App 303, 308, 758 P2d 401 (1988); *State v. Reed*, 83 Or App 451, 455, 732 P2d 66 (1987). It was appropriate for the Board to refer to the medical dictionary for the purpose of determining what the coracobrachial ligament is.

However, the Board's opinion went beyond the dictionary definition and also beyond the reasonable inferences that could be drawn from the medical evidence. While it is true that the dictionary identifies the coracobrachial ligament as a ligament of the arm involved in flexion, Vigeland's operative report gave no indication that the coracobrachial ligament had been affected by the injury or the surgery. Scheinberg's report made no reference to loss of arm <157 **Or App 227/228**> strength or to the coracobrachial ligament. The Board's finding of loss of arm strength is dependent on its own conclusion that, because the coracobrachial ligament was mentioned in Vigeland's report, it must have been involved in the loss of shoulder flexion noted in Scheinberg's report. The Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge. *See* ORS 183.450(4). Its findings must be based on medical evidence in the record. ORS 656.268(7)(g). Here, the medical evidence does not support the finding that claimant experienced a loss of arm strength.

Because it is not possible to know to what extent the Board's reliance on its finding affected its determination of claimant's award, we remand the case to the Board for reconsideration.

Reversed and remanded for reconsideration.

Cite as 157 Or App 229 (1998) November 25, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth D. LeGore, Claimant.

KENNETH D. LEGORE, Petitioner,
v.
SELF-INSURED MANAGEMENT SERVICES, Respondent.
(TP-96006; CA A99764)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 15, 1998.
Nancy FA Chapman argued the cause for petitioner. With her on the brief was Kevin Keaney.
Vera Langer argued the cause for respondent. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Before Edmonds, Presiding Judge, and Armstrong and Wollheim, Judges.
Edmonds, P. J.
Affirmed.

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157 Or App 231> Claimant seeks judicial review of a third-party order of the Workers' Compensation Board (Board) requiring that the parties take all actions necessary to effectuate an earlier order that granted all third-party settlement proceeds to the paying agency in accordance with the distribution provisions of ORS 656.591(2).[1] We affirm.

We state the facts as found by the Board in its initial order or that are uncontested. On November 27, 1993, claimant suffered a compensable injury when his truck was struck by another vehicle. Self-Insured Management Services (SIMS), the paying agency, accepted the injuries and paid compensation.[2] During the fall of 1995, claimant, through his attorney, filed a third-party claim in Wasco County Circuit Court against the driver of the vehicle. Thereafter, claimant's attorney repeatedly acknowledged to SIMS claimant's intention to assign the third-party claim to SIMS and to have SIMS incur the litigation costs in pursuing the claim. On March 6, 1996, claimant's attorney advised SIMS that "claimant intended to 'tender the [third-party] claim back to SIMS to proceed to trial.'" (Alteration in original.) SIMS's attorney responded that SIMS interpreted the communication to constitute an assignment of claimant's third-party claim under ORS 656.591. Thereafter, claimant's attorney moved to withdraw as the attorney of record in the circuit court proceedings. Claimant's and SIMS's attorneys continued to exchange correspondence regarding whether and when an assignment had been made and the legal effect of **<157 Or App 231/232>** any assignment. Apparently, during this time, claimant's attorney filed a lien pursuant to ORS 87.445[3] in the circuit court proceeding.

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[1] ORS 656.591 provides, in part:

"(1) An election made pursuant to ORS 656.578 not to proceed against the * * * third person operates as an assignment to the paying agency of the cause of action * * * of the worker * * * against the * * * third person, and the paying agency may bring action against such * * * third person in the name of the injured worker * * *.

"(2) Any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical, surgical or hospital service, together with the present worth of the monthly payments of compensation to which such worker or other beneficiaries may be entitled under this chapter, shall be paid such worker or other beneficiaries."

[2] As of November 26, 1996, SIMS had paid $27,505 in compensation.

[3] ORS 87.445 provides:

"An attorney has a lien upon actions, suits and proceedings after the commencement thereof, and judgments, decrees, orders and awards entered therein in the client's favor and the proceeds thereof to the extent of fees and compensation specially agreed upon with the client, or if there is no agreement, for the reasonable value of the services of the attorney."

SIMS's attorney conducted settlement negotiations with the driver's legal representatives and eventually sent claimant's attorney a letter stating that SIMS and the driver intended to settle the circuit court case. The letter indicated that: (1) the action would be settled for $10,000; (2) the check would be issued to claimant, his attorney and SIMS; (3) claimant, his attorney and SIMS would sign a release; and (4) the settlement proceeds would be distributed pursuant to a final third-party distribution order. Thereafter, claimant signed the release; a check payable to claimant, his attorney and the paying agency was issued; and the circuit court entered judgment dismissing the third-party claim.

Claimant and SIMS then petitioned the Board to resolve the issues concerning the distribution of settlement proceeds. Claimant argued that SIMS was not entitled to the proceeds because no assignment had occurred or that, if an assignment had occurred, it had been revoked or reassigned. The Board rejected claimant's arguments. It concluded:

> "SIMS is authorized to distribute the proceeds of the third-party recovery pursuant to ORS 656.591(2). SIMS's current uncontested lien of $27,505 attaches to the entire $10,000 settlement. * * *
>
> "Accordingly, SIMS's counsel is directed to forward the $10,000 settlement check to SIMS as partial reimbursement for its third-party lien."

That order became final when claimant failed to seek review.

When claimant's attorney failed to endorse the settlement check so that a distribution pursuant to the order could occur, SIMS requested that the Board issue a second order requiring the endorsement. Claimant argued to the **<157 Or App 232/233>** Board that its earlier order did not explicitly direct his attorney to endorse the settlement check and asserted, *for the first time*, that the Board lacked authority because of the priority of his attorney's lien. In its subsequent order, the Board reasoned:

> "ORS 656.591 gives us jurisdiction over the parties and the subject matter of claimant's assignment of his third-party claim to SIMS. Because the parties continue to have a dispute regarding the distribution of third-party settlement proceeds and because that conflict arises from a disagreement regarding our prior order addressing the assignment of claimant's cause of action under ORS 656.591, we conclude that we are authorized to resolve this matter."

(Citations omitted.) In response to claimant's arguments, the Board noted that, although "we have no authority to comment on matters outside of this third-party dispute, we do have the authority to determine, as we already have in this case, that the paying agency's lien applies to the entire third-party settlement under ORS 656.591." The Board directed the parties to "take any and all actions necessary to achieve the ultimate conclusion reached by our prior final order, *i.e.*, that SIMS is entitled to the entire proceeds of the third-party settlement." The Board noted:

> "Although we did not expressly direct claimant's counsel to endorse the check, we did find, based on the record (which included the attorneys' correspondence concerning the third-party settlement), that the parties agreed that the check would be issued to claimant, his counsel and SIMS jointly and that the settlement proceeds 'would be distributed in conformance with a final third-party distribution order.' Claimant neither challenged these findings, nor did he seek inclusion of the 'condition' which he presently asserts, i.e., that his counsel would endorse the settlement check only if so directed by the Board. Because our prior order has become final, claimant is now precluded from asserting such a condition. Moreover, such actions are in contravention of both his counsel's prior agreement and the final third-party distribution order." (Citation omitted.)

Claimant seeks review of only the Board's second order. He contends that when the Board ordered his attorney **<157 Or App 233/234>** to endorse the settlement check to SIMS, it gave priority to SIMS's lien over his attorney's lien and that the Board had no jurisdiction to determine the priority of an attorney lien created under ORS chapter 87. Furthermore, claimant contends that ORS chapter 656 does not affect the efficacy of his attorney's lien or require the satisfaction of SIMS's lien before his attorney's lien. SIMS counters that the Board had jurisdiction to resolve the continuing dispute involving the

distribution of the third-party settlement proceeds and that the issues of claimant's assignment of his third-party claim to SIMS and the proper distribution of settlement proceeds were decided conclusively in the initial order. Thus, claimant cannot collaterally attack those determinations in this judicial review. In the alternative, SIMS contends that the attorney lien provisions in ORS chapter 87 do not affect the distribution provisions under ORS chapter 656.

The Board has jurisdiction of matters concerning a claim. ORS 656.704; *SAIF v. Wright*, 312 Or 132, 136, 817 P2d 1317 (1991). Matters concerning a claim "are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). In *EBI Companies v. Cooper*, 100 Or App 246, 248-49, 785 P2d 380 (1990), we held that a dispute concerning the claimant's right to rescind an election under ORS 656.591 and the proper distribution of third-party settlement proceeds was a matter concerning a claim

> "because the worker's right to receive compensation is directly in issue. The paying agency's right to distribution of third-party recoveries is derived from its responsibility for compensation, and the amount distributed is determined in part by the amount of compensation paid. ORS 656.591 gives the Board jurisdiction over the parties and the subject matter of an election by a worker to assign his third-party claim to a paying agency."

(Citations omitted.) In *Harvey v. Lou Surcamp Logging*, 100 Or App 227, 229-30 n 1, 785 P2d 383 (1990), we held that, because a matter concerning a claim includes a dispute involving whether settlement proceeds from a third-party claim should be distributed pursuant to ORS 656.591 or ORS 656.593, the Board had jurisdiction over the disposition of the **<157 Or App 234/235>** proceeds. In accordance with those decisions, we hold that the Board had jurisdiction to enter its initial order.

We now turn to whether claimant can relitigate the settlement distribution provisions in the initial order. The rule regarding claim preclusion is that

> "'a plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [*i.e.*, precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.'"

Drews v. EBI Companies, 310 Or 134, 140, 795 P2d 531 (1990) (quoting *Rennie v. Freeway Transport*, 294 Or 319, 323, 656 P2d 919 (1982)) (alterations in original).

In *Jeld-Wen, Inc. v. Bartz*, 142 Or App 433, 436, 921 P2d 419 (1996), we held that "[c]ollateral attacks on final orders of the Board are not permitted." The facts of *Jeld-Wen* are similar to the facts of this case. In *Jeld-Wen*, the Board affirmed an administrative law judge's (ALJ's) order requiring the employer to pay certain benefits. The employer did not seek review of the Board's order, and it became final. However, the employer refused to pay the benefits as ordered. The claimant then requested that the Board's first order be enforced. An ALJ again ordered the employer to pay the benefits, and the Board affirmed. The employer sought review of the Board's second order in this court. We ruled that the employer could not litigate the validity of the first order because that would allow him collaterally to attack an order for which he had not sought judicial review.

Here, the Board's initial order resolved the dispute concerning the distribution of settlement proceeds by concluding that SIMS was entitled to all of the proceeds. Implicit in this order is the requirement that claimant's attorney effectuate the order by endorsing the settlement check. Claimant could have raised the effect of the attorney's lien on **<157 Or App 235/236>** the settlement proceeds to the Board at that time; an argument that, if successful, could have resulted in a different distribution of the proceeds. Even if the initial order was erroneous, claimant did not seek judicial review, and the initial order became final and binding on the parties. On review, claimant seeks to relitigate the same factual transaction on which the Board issued its initial order by raising a new legal theory that he could have raised in the first proceeding. It follows that claimant cannot collaterally attack the distribution provisions of the initial order.

Affirmed.

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