VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 51

(Pages 1-598)

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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.

JANUARY-MARCH 1999

Van Natta's Workers' Compensation Reporter is published quarterly by the editors, Robert Coe and Merrily McCabe. A one-year subscription costs $300 for the four quarterly volumes; a bi-monthly update service is available for an additional cost of $180. All subscription, billing, editorial and similar correspondence should be addressed to: The Editors, *Van Natta's Workers' Compensation Reporter*, 1017 Parkway Drive NW, Salem, Oregon 97304. Phone (503) 585-5173; fax (503) 540-0114. All requests for permission to make any otherwise infringing use of all or any part of this publication, including photocopying and copying for use with electronic media, should be addressed to the editors.

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CITE AS

51 Van Natta ____ (1999)

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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Salem, Oregon 97304
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1-70, WITH BOARD ORDERS FROM JANUARY 1 THROUGH JANUARY 15, 1999. THESE PAGES ARE THE FIRST INSTALLMENT OF BOARD ORDERS FOR THE FIRST QUARTER (JANUARY-MARCH) OF VOLUME 51 (1999).

LATER PAGES SHOULD BE INSERTED INTO THIS BINDER.

YOU MAY DISCARD THIS PAGE AT YOUR OWN CONVENIENCE.

In the Matter of the Compensation of
GARRET W. CRAWFORD, Claimant
WCB Case No. 98-03327
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded claimant temporary disability benefits for the period from October 20, 1995 through September 30, 1997. On review, the issue is temporary disability.

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

The ALJ, applying *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), found that claimant was entitled to substantive temporary disability benefits from October 20, 1995 through September 30, 1997.

On review, the insurer disagrees with our decisions in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996) and *Linda K. Holcomb*, 49 Van Natta 149 (1997). In *Bundy*, relying on *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992), we concluded that a claimant's substantive entitlement to temporary disability benefits, which is set forth in ORS 656.210 and 656.212, is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. After analyzing those statutes, we held that the 1995 amendments to the Workers' Compensation Law had no effect on the principle that a worker is substantively entitled to temporary disability benefits for those periods during which he is able to prove that he was unable to work as a result of his compensable injury, and that substantive entitlement to such benefits is not contingent upon authorization of time loss by the attending physician.

In *Holcomb*, we applied *Bundy*, noting that we had previously rejected the insurer's contention that ORS 656.262(4)(f) prohibits retroactive authorization of substantive, as well as procedural, temporary disability, in that case.

Although the insurer argues that *Bundy* and *Holcomb* were wrongly decided, we decline to revisit these cases. We rely on *Bundy* as precedent, as we did in *Holcomb*, and as did the ALJ in the case presently before us.[1]

Finally, the insurer argues that the ALJ erred in determining that Dr. Burt became claimant's attending physician for the purposes of authorizing temporary disability benefits for the entire period in question. We disagree with the insurer's argument for the following reasons.

A worker is substantively entitled to temporary disability benefits for those periods during which he is able to prove that he was unable to work as a result of his compensable injury. *Substantive entitlement to such benefits is not contingent upon authorization of time loss by the attending physician.* (Emphasis added). *Kenneth P. Bundy*, 48 Van Natta at 2501. Thus, the dispositive question in establishing entitlement to substantive temporary disability is not authorization by an attending physician, but record evidence that claimant was unable to work as a result of his compensable injury.

After our review of the record, we agree with the ALJ's finding that claimant was unable to work as a result of his compensable injury from October 20, 1995 through September 30, 1997, the date surgery was performed.[2] Dr. Davis placed claimant on modified work as of October 12, 1995. On

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[1] We note that the Court of Appeals applied the same principle in *Shaw v. Rebholz*, 152 Or App 328 (1998). In *Shaw*, the court applied *SAIF v. Taylor*, 126 Or App 658, 660-61 (1994), which holds that the determination of the amount of claimant's substantive temporary disability benefits at the time of claim closure is based on the extent to which claimant demonstrates continuing disability during the pendency of the open claim. *See also Santos v. Caryall Transport*, 152 Or App 322 (1998) (rejecting argument that entitlement to the benefits at closure relies on a distinction between "substantive" and "procedural" entitlements that has been legislatively overruled).

[2] The parties do not dispute the Order on Reconsideration's finding that claimant was entitled to temporary disability October 12 through October 20, 1995, and from September 30, 1997 through February 4, 1998.

October 16, 1995, the insurer fired claimant from his job on the ground he lied about the circumstances of his injury. On October 27, 1995, the insurer denied claimant's claim on the basis that he did not sustain an injury or occupational disease. A January 16, 1997 Opinion and Order found that claimant's relation of the circumstances of the injury were due to claimant's innocent misunderstanding of anatomy, spinal injuries, and his own medical history, and set aside the insurer's denial of claimant's occupational disease claim. (Ex. 21). This opinion was affirmed by the Board.

Therefore, at the time claimant was fired, he remained able to work a modified schedule. Accordingly, claimant was entitled to temporary disability benefits as of the date his job was eliminated. Claimant subsequently underwent surgical consultation from Dr. Bert on referral from Dr. Davis. (Ex. 11-2). Dr. Bert determined that claimant should undergo instrumented fusion surgery if he was to return to the work force. (Ex. 16). Dr. Bert also stated that claimant was unable to work due to his compensable injury from October 1995 until surgery. (Ex. 29). On this record, therefore, we conclude that claimant has proven that he was unable to work as a result of his compensable injury from October 20, 1995 through September 30, 1997, and is entitled to substantive temporary disability benefits for that period.

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

ORDER

The ALJ's order dated September 3, 1998 is affirmed. For services on review concerning the temporary disability issue, claimant's counsel is awarded a reasonable assessed attorney fee of $1,500, payable by the insurer.

Board Member Moller specially concurring.

For the reasons set forth in my dissenting opinion in *Kenneth P. Bundy*, 48 Van Natta at 2506-08, I remain persuaded that, by enacting ORS 656.262(4)(f) and 656.268(3)(d), with regard to the issue before us here, the legislature eliminated the "procedural-substantive" distinction for temporary disability and required that the attending physician authorize any award of temporary disability. Under the doctrine of stare decisis, however, I am obligated to follow the majority's holding in *Kenneth P. Bundy* unless and until the court reverses *Bundy* or its conclusion is legislatively overruled.

In the Matter of the Compensation of
BETH A. WOOD, Claimant
WCB Case No. 98-02228
ORDER OF DISMISSAL
Ernest M. Jenks, Claimant Attorney
Zimmerman, Nielsen, et al, Defense Attorneys

Claimant requested review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's aggravation claim for a right knee condition. The briefing schedule was suspended in response to claimant's announcement that the parties had settled their dispute. Thereafter, the parties submitted a proposed "Disputed Claim Settlement Pursuant to ORS 656.289(4)," which is designed to resolve "all issues raised or raisable" between the parties that are pending in this case, as well as those that were pending before the Hearings Division in WCB Case No. 98-07973. Those portions of the settlement that pertain to the Hearings Division have previously received ALJ approval.[1]

[1] Because the agreement refers to WCB Case No. 98-02228 (which is the case pending Board review) and because the settlement purports to unequivocally "settle all issues raised or raisable" involving the parties, approval from both the ALJ (regarding those issues pending before the Hearings Division in WCB Case No. 98-07973) and the Board are required. OAR 438-009-0015(5).

Pursuant to the settlement, claimant agrees that "[t]he denial is affirmed and this claim shall remain denied." Claimant further stipulates that she is not entitled to compensation for her denied claim. Finally, the settlement provides that claimant's "Requests for Hearing shall be dismissed with prejudice as to all issues raised or raisable at any time relating to the denied conditions."

By this order, we have approved those portions of the parties' settlement that pertain to issues pending before the Board, thereby fully and finally resolving this dispute. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

January 6, 1999 Cite as 51 Van Natta 3 (1999)

In the Matter of the Compensation of
MARK S. LEHMAN, Claimant
WCB Case No. 97-07612
ORDER ON REVIEW
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by the Board *en banc*.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside a Director's order that suspended claimant's compensation for failing to cooperate with SAIF's claim investigation; and (2) set aside SAIF's "noncooperation" denial of claimant's injury claim pursuant to ORS 656.262(15). On review, the issues are propriety of the suspension order and denial. We reverse.

FINDINGS OF FACT

Claimant filed a claim for a March 4, 1997 right toe injury. He retained an attorney in late May 1997 and left Oregon in early June 1997.

Claimant did not contact his attorney or SAIF or provide either with an address or telephone number while he was out of state.

On June 16 and June 20, 1997, SAIF sent claimant notices of its intent to take recorded statements from him. Claimant's attorney responded that claimant had moved without leaving a mailing address.

On July 23, 1997, SAIF wrote to the Department of Consumer and Business Services (DCBS) requesting authorization to suspend benefits based on claimant's failure to cooperate with its investigation.

On August 6, 1997, DCBS wrote to claimant to inform him that his benefits would be suspended unless within five working days he contacted it documenting that his failure to cooperate was reasonable or SAIF notified it that claimant was cooperating. The letter also stated that the claim might be denied if claimant did not cooperate within an additional 30 days.

On August 19, 1997, having received no information from claimant or SAIF, DCBS issued an order suspending claimant's compensation pursuant to ORS 656.262(15). This order was sent to claimant's last Oregon address via regular and certified mail. The order provided: "Should the worker agree to give the required interview, the insurer is instructed to schedule it at the earliest possible date to reinstate the worker's benefits."

On September 8, 1997, SAIF denied claimant's claim, based on claimant's failure to cooperate with the investigation of his claim for more than 30 days following DCBS' August 6, 1997 notice.

On September 18 and 19, 1997, claimant's attorney requested a hearing from the denial and notified SAIF and the Workers' Compensation Board that he withdrew as claimant's counsel.

Claimant returned to Oregon in November 1997.

A hearing convened on May 13, 1998. Claimant appeared *pro se.*

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial, reasoning that claimant's non-cooperation with SAIF's investigation was "justified by his need to eat and his having turned over his affairs to an attorney in his absence." The ALJ also determined that the denial should be set aside because SAIF did not strictly comply with the requirements of ORS 656.262(15) in issuing its denial. In this regard, the ALJ found that the denial issued 20 days after DCBS' August 19, 1997 order, but the statute required passage of 30 days. We disagree that the denial should be set aside.

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

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

We have previously found that the legislative intent behind the phrase "reasons beyond the worker's control" is apparent from the statutory text and context. *See Patti E. Bolles,* 49 Van Natta 1943 (1997).

In this case, claimant's explanation for failing to cooperate with SAIF's investigation in July 1997 is that he was in California. He did not contact his attorney or SAIF while he was out of state, from June 1997 until November 1997, and he stated at hearing that his attorney was unable to contact him during that time. (Tr. 8, 20). Claimant assumed that his attorney would take care of matters concerning his claim while he was absent from Oregon. (Tr. 20).

We decline to hold claimant's former counsel responsible for claimant's failure to respond to SAIF's letters, when it is undisputed that claimant did not tell the attorney where he was. Here, as in *Geoff McClellan,* 50 Van Natta 43, 44-45 (1998), we find that claimant should have anticipated receiving communication about his claim. We also find that it was within his control to maintain contact with his attorney and thereby facilitate timely responses to SAIF's investigative demands. Claimant's lack of diligence in this regard was the reason he did not fully cooperate with the investigation of his claim.

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

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

Because his lack of diligence was a matter within his control, the Director's suspension order should not be set aside on this basis.[2]

ORS 656.262(15) provides that an insurer may deny the claim (for failure to cooperate) after a Director's order suspending compensation, "if the worker does not cooperate for an additional 30 days[.]" In this case, we have determined that claimant failed to cooperate with SAIF's investigation for reasons *within* his control. There is no indication that claimant's reasons for noncooperation changed during the 30 days after the suspension notice.

This case differs significantly from *Jodie M. Dubose*, 50 Van Natta 1822 (1998). There, we set aside a suspension order because the worker was unable to attend an insurer-arranged medical examination for reasons beyond her control. In other words, the worker *had* a reasonable explanation for failing to cooperate with the carrier's initial investigation. The carrier argued that we nevertheless should uphold its "noncooperation" denial because the claimant "did nothing" during the 30-day period between the suspension notice and the denial. We disagreed and set the denial aside, finding no evidence that the claimant failed to submit to an information gathering technique during that time.

In *Dubose*, the claimant *had* a reasonable explanation for failing to cooperate with the initial investigation, so it was necessary to evaluate whether there was a *post*-suspension failure to cooperate to determine whether the "noncooperation" denial was appropriate. Here, in contrast, claimant's explanation is inadequate to challenge the suspension order or the denial, so no new investigation and "noncooperation" is necessary to support the denial.

Accordingly, because claimant has not established that SAIF's investigative demands were unreasonable or that he failed to cooperate with those demands for reasons beyond his control, we reinstate SAIF's denial.

ORDER

The ALJ's order dated June 12, 1998 is reversed. The Director's suspension order is affirmed. The SAIF Corporation's denial is reinstated and upheld.

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[2] The ALJ also implicitly found SAIF's investigative demands unreasonable, because it allowed claimant only four days' notice before the first interview date in June 1997 and because the first request was made 102 days after the employer's knowledge of the claim. We do not find SAIF's initial scheduling unreasonable *per se*. Moreover, even assuming (without deciding) that the first 4-day interview notice was unreasonably short, we note that SAIF attempted to immediately schedule another interview and the second request allowed claimant 14 days to cooperate or request rescheduling. (Ex. 2). Thus, in our view, the second request "cured" any unreasonable immediacy of the first. Under these circumstances, we are not persuaded that the timing of SAIF's interview requests or the notice provided by the requests constitute unreasonable investigative demands. We also disagree with the ALJ's finding that SAIF's denial was premature because it issued 20 days after the Director's order suspending claimant's compensation.

ORS 656.262(15) provides that a carrier may deny a claim for non-cooperation 30 days after the Department sends notice to the worker regarding suspension of benefits for non-cooperation. In this case, the Department's notice was sent to claimant on August 6, 1997 and the denial issued more than thirty days later, on September 8, 1997. Under these circumstances, we do not find that SAIF failed to comply with the statutory requirements in issuing its denial or that the denial was premature or otherwise procedurally defective.

Board Member Biehl dissenting in part.

I agree with the majority that claimant failed to cooperate with SAIF's initial investigation for reasons within his control and the suspension order must therefore be upheld. But it does not necessarily follow that the "noncooperation" denial should be upheld solely because the suspension order is upheld. On the contrary, I would set aside the denial, because SAIF made no attempt to investigate the claim after the suspension order.

ORS 656.262(15) provides that an insurer may deny the claim (for failure to cooperate) after a Director's order suspending compensation, "if the worker does not cooperate for an additional 30 days[.]" The majority reasons that SAIF was not required to investigate the claim during the "post suspension/pre-denial" 30 days, because claimant's explanation for failing to cooperate *initially* was inadequate.

But the ALJ noted --and SAIF does not dispute-- that there is no evidence that SAIF attempted to contact claimant or investigate the claim after the suspension order, even though claimant has "indicated his willingness" to cooperate with claim investigation. Opinion and Order, p. 4. This case clearly has appropriate facts for treating a suspension order and a "noncooperation" denial separately: Because there is no evidence that claimant failed to cooperate *with an investigation* after the Director's suspension notice, the "noncooperation" denial should be set aside.

The practical effect of this result would be that claimant's right to compensation (and SAIF's obligation to process the claim) would remain suspended under the Director's suspension order until claimant cooperates with claim investigation. If SAIF seeks claimant's cooperation and claimant does not cooperate, SAIF could choose to issue another "noncooperation" denial. On the other hand, if claimant cooperates, the suspension would end and SAIF's obligations to accept or deny the claim would be reinstated. Unlike the majority's result, this approach would more likely achieve substantial justice, because the claim would be accepted or denied on its merits.

In my view, the statutory scheme requires meaningful claim investigation *before* issuance of a claim denial --even a "noncooperation" denial. Accordingly, I must respectfully dissent from that portion of the majority's order that upholds SAIF's denial.

In the Matter of the Compensation of
JAMES V. COMPTON, Claimant
WCB Case No. C8-02692
SECOND 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.

The SAIF Corporation has requested reconsideration of our December 15, 1998 order denying reconsideration of the claim disposition agreement (CDA) approved on November 24, 1998. SAIF argues that the approved CDA is void because it was not approved by the Director. In addition, SAIF argues that it has "good cause" for its untimely filing of the addendum to the previously approved CDA. Claimant joins the request for reconsideration. We deny the motion for reconsideration.

On November 24, 1998, we approved the parties' CDA. On December 8, 1998, more than 10 days after the CDA was approved, we received the parties' addendum to the CDA, which provided for reimbursement of $131,921.68 of the CDA proceeds by the Workers' Benefit Fund. The addendum contained the signature of the Director's representative. We treated the addendum as a motion for reconsideration of the approved CDA. On December 15, 1998, we denied reconsideration of the CDA because the motion for reconsideration was untimely filed under OAR 438-009-0035.

On December 21, 1998, we received SAIF's motion for reconsideration of our order denying reconsideration of the CDA. The motion for reconsideration indicates that the Director has authority to authorize reimbursement for a portion of the CDA proceeds under ORS 656.625, pursuant to the Reopened Claims Program. In the motion for reconsideration, SAIF cites *Henry M. Parnell*, 43 Van Natta 1631 (1991), and argues that the original CDA was void because it did not contain the Director's approval. For the following reasons, we find the CDA in *Parnell* to be distinguishable from the present CDA

In *Parnell*, after the parties' original CDA was approved, the insurer requested reconsideration in order to rectify the parties' failure to obtain the Director's approval for reimbursement from the Handicapped Workers' Reserve (HWR). We denied the insurer's motion for reconsideration as untimely. Thereafter, we became aware that the claim had been granted HWR relief prior to the execution of the CDA by the parties.

Citing ORS 656.628(7), which provided that any settlement, including a CDA, of an HWR qualified claim was void unless approved by the Director, we found that the original CDA was "void" because it was entered into without the Director's approval. We approved a revised CDA which contained the Director's representative's signature approving reimbursement from the HWR.

Here, in contrast to *Parnell*, the claim does not involve the HWR. Instead, the claim involves the Reopened Claims Program and ORS 656.628(7) does not apply. ORS 656.625, the statute which pertains to the Reopened Claims Program, contains no provision similar to that in ORS 656.628 which provides that a settlement is "void" without the Director's approval. The Director's administrative rules regarding the Reopened Claims Program likewise contain no rule specifying that a settlement is "void" absent the Director's approval. OAR 436-045-0020(2) does specify that "[d]ispositions * * * are not eligible to receive reimbursement from the Reopened Claims Program unless made with the prior written approval of the Director." The rule, however, does not state that the disposition is void without the approval of the Director. Under such circumstances, we find the CDA in *Parnell* to be distinguishable from the present CDA. Specifically, here, unlike in *Parnell*, there is no statutory or administrative provision providing that the CDA is void because it does not contain the Director's prior approval.

SAIF next argues that it had "good cause" for its untimely submission of the motion for reconsideration. Specifically, SAIF asserts that 4 of the 10 days after approval of the original CDA were non-business days and additional days were taken waiting for the Director's approval. On this basis, SAIF argues that "good cause" has been established for its late motion for reconsideration.

OAR 438-009-0035 provides:

"(1) A motion for reconsideration of final orders issued by the Board under ORS 656.236 and these rules *shall be filed within 10 days of the date of mailing of the order.*

"(2) The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration:

"(a) Is filed in accordance with section (1) of this rule; and

"(b) States specifically the reason(s) reconsideration is requested.

"(3) Reconsideration of a final order issued by the Board under ORS 656.236 and these rules shall be limited to the record before the Board at the time its final order was mailed and additional information will be considered, unless the Board finds good cause for allowing the additional submission." (Emphasis added).

First, we note that OAR 438-009-0035 allows the parties to establish good cause for the Board to consider additional information that is submitted *within* the 10 day reconsideration period, but *does not* provide an opportunity for parties to establish good cause excusing their failure to timely submit a motion for reconsideration. OAR 438-009-0035 strictly provides for a time limit of 10 days from the date of the mailing of the order approving the CDA. The rule does not say 10 *business* days. Moreover, even if the rule allowed parties to establish "good cause" excusing an untimely motion, SAIF does not assert that it advised the Director that the addendum must be submitted to the Board within 10 days. Under such circumstances, we continue to find that the motion for reconsideration was untimely filed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUTH L. EASLEY, Claimant
WCB Case No. 98-02820
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our December 10, 1998 order that adopted and affirmed an Administrative Law Judge's (ALJ's) order setting aside SAIF's denial of claimant's occupational disease claim for a right thumb arthritis condition. SAIF contends that we erred in finding that claimant had no preexisting condition, where no evidence indicated that a right thumb condition preceded claimant's (12 1/2 year) employment with its insured. SAIF relies on the text of the definition of "preexisting condition" in ORS 656.005(24); legislative history of that statute;[1] the text of the definition of "claim" in ORS 656.005(6); and cases (before enactment of ORS 656.005(24)) describing the "onset" or date of "injury" in occupational disease claims.

ORS 656.802, defining occupational diseases, provides in relevant part that:

"(2)(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2).

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 injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." ORS 656.005(24).

A "claim" is defined as

"a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6).

SAIF contends that the ORS 656.005(6) definition of "claim" -- referencing claim *filing,* is incorporated into the 656.005(24) definition of "preexisting condition," -- specifically, the phrase "precedes the onset of an initial *claim.*" Thus, because claimant had right thumb arthritis before she *filed* her occupational disease claim, SAIF contends that she had a "preexisting condition," for purposes of proving compensability under 656.802(2).

Another insurer made the same argument, on similar facts, in *New Portland Meadows v. Dieringer,* 153 Or App 383, 387 (1998). The court disagreed, holding that, where there was no evidence that the claimant's condition preceded her subject employment with the insured and the claim was the first one for the disease, the claimant's condition did not precede the onset of the claim. Therefore, the court concluded that there was no "preexisting condition" for purposes of establishing compensability. Based on *Dieringer* and the cases cited in our initial order,[2] we reach the same result here on reconsideration.

We offer the following additional comments.

The issue is whether claimant's "pre-claim-filing" condition amounts to a preexisting condition for purposes of establishing compensability under ORS 656.802(2). Claimant contends that SAIF's proposed construction of the statute leads to an absurd result, because all occupational diseases exist to

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[1] SAIF quotes commentary by Representative Kevin Mannix.

[2] *See also Audrey Keeland,* 50 Van Natta 2041, 2042 (1998); *Michael D. Cessnun,* 50 Van Natta 1541 (1998); *Douglas G. Andrews,* 50 Van Natta 919, 920 (1998); *Mark A. Davidson,* 49 Van Natta 1918, 1919-20 (1997); *Joan L. Kearns,* 49 Van Natta 1598, 1599 (1997).

some extent before they are manifest. Moreover, claimant asserts that, under SAIF's approach, all occupational diseases would involve preexisting conditions and this would not comport with the alternative subsections of ORS 656.802(2) (which acknowledge that some occupational disease claims are *not* based on a worsening of a preexisting condition). We agree with claimant.

Occupational disease claims are, by common law definition, gradual in onset and insidious, or unexpected. *See Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343 (1981). Virtually all occupational diseases exist before claims are filed, because they are filed after they are discovered and they are not discovered until after onset. But subsections (a) and (b) of ORS 656.802 impose *alternative* burdens for proving compensability, depending on whether the claim is based on a worsening of a preexisting condition. Under SAIF's reading of the statute, *all* occupational diseases would be "based on a worsening" -- simply because all conditions precede claim filing.[3] We decline to adopt a construction of the statute that renders a portion meaningless,[4] especially where the text and context[5] of the statute invite a contrary, meaningful interpretation: Here, as in *Dieringer*, the claim (as defined by claimant, rather than the statute) is not *"based on"* the worsening of a preexisting disease or condition. This claim is an initial claim, based on the entire work exposure, and there is no evidence that the condition preceded the exposure. Consequently, we continue to agree with the ALJ that no preexisting condition preceded claimant's 12 1/2 year work exposure, and the claim is compensable.

Claimant's counsel is entitled to an additional 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 case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $300, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the motion), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our December 10, 1998 order. On reconsideration, based on *Dieringer* (and having considered the unambiguous text and context of ORS 656.802(2)), we adhere to and republish our December 10, 1998 order, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[3] SAIF relies on *Medford Corp. v. Smith*, 110 Or App 486 (1992), to define the word "onset" in ORS 656.005(24). Because the onset of the disease in *Medford* occurred when the claimant first sought treatment for his disease and apparently because claimant filed her claim here after she sought treatment (actually, claimant filed the same day), SAIF contends that claimant's condition preceded the onset of her claim. But, in *Medford*, the claim against SAIF, the insurer at the onset of the disease, was precluded because the claimant had not appealed SAIF's prior denial. The compensability of the claim did not depend on whether the claimant had a preexisting condition. The *Medford* court held that the claim would be compensable if the claimant's "non-SAIF" employment was the major cause of the condition. Moreover, the court stated, "We do not understand employer's attempt to distinguish responsibility for 'exposure' from responsibility for the disease itself." *Medford*, 110 Or App at 488. We have a similar reaction to SAIF's argument here. In any event, *Medford* is neither controlling nor instructive.

SAIF also cites *Papen v. Willamina Lumber Co.*, 123 Or App 249 (1993), *rev den* 319 Or 81 (1994) and *Mathel v. Josephine County*, 319 Or 235 (1994). In *Papen*, the "date of injury" for the occupational disease claim was the date the claimant first sought treatment for his hearing loss condition (not the date of last work exposure, as the claimant argued). But the issue was extent of permanent disability, specifically offset of measured hearing loss. In *Mathel*, the issue was whether the claimant's heart attack was properly analyzed as an injury or occupational disease. Neither of these cases address the issue before us now. They do not say that the ORS 656.005(6) definition of "claim" is incorporated in the *later-enacted* ORS 656.005(24) definition of a "preexisting condition." *See Moe v. Motor Vehicles Div.*, 133 or App 75, 79, n.1 (1995) (The suggestion that prior judicial construction actually becomes a part of the language of the statutes themselves "should be understood as a colloquial fiction, articulated for the purpose of emphasizing the particular importance of stare decisis in considering prior construction of statutes.") (citing, *inter alia, Mathel*, 319 Or at 239-40).

[4] *See* ORS 174.010; *Northwest Alliance for Market Equality v. Department of Revenue*, 318 Or 129, 133 (1993).

[5] We note that ORS 656.003 provides that the definitions in ORS Chapter 656 govern its construction, *"[e]xcept where the context otherwise requires."*

In the Matter of the Compensation of
MERLE L. BUCKLEY, Claimant
WCB Case No. 98-02765
ORDER ON REVIEW
Malagon, Moore, 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) Spangler's order that assessed a $3,000 attorney fee. 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 current psoriasis condition. 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. 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 the ALJ was *required* by the rule to make findings of fact under *each* of the eight factors in OAR 438-015-0010(4); draw conclusions from those specific findings of fact; and demonstrate how those conclusions should be weighed in determining a reasonable attorney fee. We disagree with SAIF's arguments, as we recently explained in *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, as in *Underwood*, the ALJ was 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.

However, the ALJ in this case simply ordered SAIF to pay claimant's attorney "an assessed fee of $3,000 for his services in setting aside its denial, to be paid in addition to claimant's compensation." 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.

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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."

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. The parties agreed on certain "Stipulated Facts" and submitted the case to the ALJ on the documentary record. The record consists of 20 exhibits, including a letter by claimant's treating physician, responding to claimant's counsel's inquiries in a manner favorable to claimant's position.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average medical complexity and above average legal complexity (considering the *res judicata* issue and the potential "back-up" denial and "ORS 656.262(6)(c)" issues). The value of the interest and benefit secured were significant, considering the debilitating nature of claimant's compensable psoriasis condition. Both attorneys are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the potential legal complexity of the case.

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 issues, the value of the interest involved, and the risk that counsel might have gone uncompensated. Finally, claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 2, 1998 is affirmed.

January 8, 1999 Cite as 51 Van Natta 11 (1999)

In the Matter of the Compensation of
BRENDA HOARD, Claimant
WCB Case No. 98-01600
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) McWilliam's order that set aside its denial of claimant's low back injury claim. In her respondent's brief, claimant contests that portion of the ALJ's order that declined to assess a penalty for an allegedly unreasonable denial.[1] On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except that we replace "Notice of Clam" with "Notice of Claim."

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[1] The insurer objects to claimant raising the penalty issue on the basis that she did not formally request review of that matter. It is well-settled that a non-appealing party may raise additional issues in its respondent's brief, and we are authorized to address those issues, provided that the formal request for review has not been withdrawn. *Eder v. Pilcher Construction*, 89 Or App 425 (1988).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that, on December 11, 1997, while working, claimant experienced the onset of low back pain which radiated into her left thigh. The next day, claimant sought treatment. A subsequent MRI revealed a herniated disc at L5-S1; claimant underwent surgery.

Applying ORS 656.005(7)(a)(B), the ALJ decided that claimant proved compensability of her low back condition. In particular, the ALJ found that claimant's treating neurosurgeon, Dr. Van Pett, provided the most persuasive medical opinion. On review, the insurer challenges this conclusion, asserting that Dr. Van Pett's opinion is confusing and conclusory and refuted by reports from examining neurologist, Dr. Brooks, and orthopedic surgeon, Dr. Baker.

The panel of Drs. Brooks and Baker diagnosed degenerative disc disease and found that claimant's low back pain was the result of such condition. (Ex. 7-5). Moreover, the panel found no evidence of L5-S1 radiculopathy and, thus, considered the herniated disc to be an "incidental finding" and unrelated to claimant's symptoms.

Subsequently, Dr. Van Pett examined claimant and recorded that claimant's "current symptoms and clinical findings correlate with the reported on the job injury." (Ex. 8-5). Although Dr. Van Pett "acknowledge[d] that a pre-existing chronic back pain condition exists," she thought that "the acute on-the-job injury is the major contributing cause of the need for treatment and surgery." (*Id.*)

Dr. Van Pett then indicated that she did not agree with the examining panel's report; in particular, she stated that claimant's "leg pain, * * * is related to her injury and is the major contributing cause of the need for treatment and surgery" but that the "back pain is unrelated, it is chronic." (Ex. 13-1). Similarly, Dr. Van Pett also reported that claimant's "mopping activities at work are the major contributing cause of her current disability, but it is related to her leg pain, not her back pain." (*Id.*)

Dr. Brooks provided an additional report explaining that claimant's symptoms as she reported them during the panel's examination were not consistent with S-1 radiculopathy. (Ex. 15-2). Dr. Brooks further stated that, "[h]aving reviewed Dr. Van Pett's examination, I can see why she might lean towards considering an S-1 radiculopathy," although he considered those findings supporting such a diagnosis to be "minimal." (*Id.*) Finally, Dr. Brooks reported that he did not agree that "mopping would bring into play significant enough forces [to cause] a disc to herniate" and that, based on claimant's history of prior low back pain, her symptoms were due to a degenerative disc disease. (*Id.* at 3).

Dr. Van Pett then concurred in a "check-the-box" report stating that "the L5-S1 disc injury is a new condition, caused by the industrial mopping cited in [claimant's] history, and the L5-S1 injury is separable from any pre-existing pathology." (Ex. 16-2). In Dr. Van Pett's final report, she agreed with Dr. Brooks' "discussion regarding S1 radiculopathy" and explained that, when she examined claimant, she "had evidence of S1 nerve root involvement." (Ex. 17-1). Dr. Van Pett further explained that findings at surgery "correlate with reduced spinal canal size caused by degenerative changes thus predisposing her to disc herniation as well as making it more likely that more than one nerve root will get affected." (*Id.*) Dr. Van Pett ended by saying that her "opinion as to cause remains the same." (*Id.*)

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *E.g., Weiland v. SAIF*, 64 Or App 810 (1983). Furthermore, we find most persuasive those opinions that are well-reasoned and based on an accurate history. *E.g., Somers v. SAIF*, 77 Or App 259 (1986).

We find persuasive reasons not to defer to Dr. Van Pett's opinion. First, she provides no explanation how claimant's mopping activities caused a herniated disc. We find such absence important in light of Dr. Brooks' statement that such activities would not generate sufficient force to cause the condition.

Moreover, Dr. Van Pett's opinion is confusing and inconsistent with regard to contribution from the preexisting degenerative condition. In particular, Dr. Van Pett indicated in the "check-the-box" report that the herniated disc was "separable" from the preexisting condition, and then stated that "degenerative changes" predisposed claimant to a herniated disc.

In short, we find Dr. Van Pett's opinion to be insufficiently persuasive to carry claimant's burden of proof. Thus, we conclude that claimant failed to prove compensability.

Penalties

In the absence of "amounts then due," whether or not the insurer's denial was unreasonable, claimant is not entitled to a penalty. *See* ORS 656.262(11)(a).

ORDER

The ALJ's order dated September 11, 1998 is reversed in part and affirmed in part. That portion of the order setting aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
LORI L. KOWALEWSKI, Claimant
WCB Case No. 98-02362
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that affirmed an Order on Reconsideration that awarded 15 percent (20.25 degrees) scheduled permanent disability for loss of use or function of the right foot (ankle). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her right ankle on July 26, 1996. An October 13, 1997 Determination Order awarded 2 percent scheduled permanent disability. Claimant requested reconsideration and a March 5, 1998 Order on Reconsideration awarded 15 percent (20.25 degrees) scheduled permanent disability for loss of use or function of the right foot (ankle). The insurer requested a hearing and the ALJ affirmed the Order on Reconsideration, which consisted of 9 percent impairment for lost range of motion, 5 percent impairment for a chronic condition and 1 percent impairment for strength loss.

On review, the insurer argues that the burden of proof was incorrectly placed with it,[1] that the ALJ should have relied on the attending physician's findings rather than those of the medical arbiter, and that claimant is not entitled to an award for a chronic condition limiting repetitive use.

The insurer argues that the medical arbiter's findings should not be used to rate impairment because claimant had a temporary flare-up at the time of the arbiter examination.

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[1] On review, the insurer asserts its disagreement with our decision in *Roberto Rodriguez*, 46 Van Natta 1722 (1992). *Rodriguez* supports the ALJ's determination that the burden of proof should be placed with the insurer as the party that appealed from the Order on Reconsideration. We have previously declined to revisit *Rodriguez*, and we have relied on it as precedent. *See Lanny K. Sigfridson*, 49 Van Natta 1433 (1997); *Maria Jolley*, 48 Van Natta 2316 (1996); *Michael W. Weber*, 48 Van Natta 2269 (1996). We continue to take that approach in this case.

We do not automatically rely on the 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).

Here, the medical arbiter, Dr. Bald, indicated in his report that claimant had noticed loss of mobility in her ankle since returning to work in September 1997 and also noted some fatiguability in the calf that had increased over the last few months. The insurer cites this information as evidence that claimant's condition changed after the closing report such that the medical arbiter's findings are not reliable. We do not find this evidence sufficient to establish that the medical arbiter's findings should not be relied upon. In this regard, there is no indication that claimant was no longer medically stationary or that the findings do not represent permanent residuals of the compensable injury.

Based on this record, we find the medical arbiter's report to be the most well-reasoned and complete evaluation of claimant's impairment. Thus, we are more persuaded by the medical arbiter's findings. In addition, we also note that claimant's attending physician's (Dr. Higgins) findings were made in September 1997 whereas Dr. Bald's findings were made on February 23, 1998, much closer in time to the March 5, 1998 Order on Reconsideration. Thus, we find Dr. Bald's report to be a more accurate description of claimant's disability as of the date of the Order on Reconsideration. *See* ORS 656.283(7) (evaluation of a worker's disability is as of the date of issuance of the reconsideration order). Under such circumstances, we agree with the ALJ's reliance on the arbiter report in rating claimant's permanent disability.[2]

Finally, the insurer argues that the medical arbiter's report does not support a chronic condition award. We agree.

The medical arbiter reported: "It is my opinion based upon today's examination that the claimant will have *some slight limitations* related to the repetitive use of her right foot and ankle that are felt to be a direct result of the accepted condition * * *." (Ex. 32-5) (Emphasis added).

The administrative rule that is applicable, OAR 436-035-0010(5) (WCD Admin. Order 96-072), provides, in relevant part:

> "A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is *significantly limited* in the repetitive use of one or more of the following four body parts: * * * (a) Lower leg (below knee/ foot/ankle) * * *."

Here, we are not persuaded that Dr. Bald's statement that claimant had *some slight limitations* related to the repetitive use of her right foot and ankle establishes that she is *significantly limited* in the repetitive use of her right foot/ankle. In this regard, the doctor reported a limitation that was less than significant, i.e., a "slight" limitation. Under such circumstances, the insurer has established that claimant is not entitled to a chronic condition award for the right foot/ankle.

Claimant's impairment from lost range of motion (9 percent) is combined with her loss of strength (1 percent) to equal 10. Claimant is entitled to 10 percent scheduled permanent disability for loss of use or function of the right foot/ankle.

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[2] The cases relied on by the insurer to argue that claimant's condition changed since the closing examination are either distinguishable or consistent with our decision in this case. In *James C. Risener*, 50 Van Natta 181 (1998), we did not rely on the medical arbiter's opinion because the arbiter concluded that the claimant's condition was not medically stationary on the date of the examination. In addition, the claimant's condition had compensably worsened between the date of closure and the date of the medical arbiter examination. Here, the medical arbiter did not indicate that the claimant's condition was not medically stationary at the time of his exam and claimant's condition did not compensably worsen after closure, but before the arbiter exam. Thus, we find *Risener* distinguishable. In *Maureen E. Bradley*, 49 Van Natta 2000 (1997), and *Kyle L. Ellis*, 49 Van Natta 557, n. 2 (1997), we relied on the medical arbiter report because that report was more probative of the claimant's impairment as of the date of the Order on Reconsideration. We find *Bradley* and Ellis consistent with our decision in this case.

Because we have found that the compensation awarded by the Order on Reconsideration should be reduced, we reverse the ALJ's award of an attorney fee pursuant to ORS 656.382(2).

ORDER

The ALJ's order dated July 10, 1998 is modified. In lieu of the ALJ/Order on Reconsideration award of 15 percent (20.25 degrees), claimant is awarded 10 percent (13.5 degrees) scheduled permanent disability for the right foot/ankle.

In the Matter of the Compensation of
JEANNIE A. KRAMER, Claimant
WCB Case No. 98-04385
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We delete the first two sentences of the first paragraph of the findings of fact and replace them with the following:

> "Since 1990, claimant has worked for different employers, primarily as a customer service clerk. Her work activities have included cutting meat or fish, wrapping meat, waiting on customers, using a meat grinder, "prep" work and cleanup work."

In the second paragraph of the findings of fact, we change the first sentence to read: "On August 15, 1997, claimant began working for the employer as a customer service clerk at the rate of $10 per hour and approximately 40 hours a week." We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant relied on the last injurious exposure rule to establish compensability of her bilateral carpal tunnel syndrome (CTS). The ALJ relied on Dr. Phipps' opinion to conclude that claimant's work activities over the last 8 to 10 years were the major contributing cause of her bilateral CTS.

On review, the insurer argues that Dr. Phipps' opinion is not persuasive because it was based on an inaccurate understanding of claimant's job duties and it lacks adequate explanation. For the following reasons, we agree with the insurer.

We analyze claimant's occupational disease claim under the last injurious exposure rule. *See Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998) (last injurious exposure rule of proof is applicable in any case in which the evidence supports its application). To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of her CTS. ORS 656.802(2)(a).

Because of the passage of time and the number of potential causes of claimant's CTS condition, the causation issue presents a complex medical question requiring competent medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

At hearing, claimant relied on Dr. Phipps' opinion to establish compensability. Claimant testified that she considered Dr. Vigeland to be her treating physician. (Tr. 25). Dr. Vigeland referred claimant to Dr. Phipps to have a nerve conduction study. (Tr. 25, Ex. 12). In evaluating medical opinions, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, even if we assume Dr. Phipps is claimant's treating physician, he examined claimant on only one occasion. (Ex. 12). Under these circumstances, we do not grant any particular deference to Dr. Phipps' opinion.

On March 4, 1998, Dr. Phipps reported that claimant "works as a meatcutter." (Ex. 12-1). He did not discuss any of her job activities in his initial report. He merely stated that "she has had problems with her hands for a couple of years but that this problem became more significant in about November." (*Id.*) In a later report on May 4, 1998, Dr. Phipps explained:

> "[Claimant] has worked as a meat cutter since basically 1990 and all of that exposure contributed to her ultimate diagnosis of carpal tunnel syndrome. She does describe that her current work is rather different and it would appear that this work exposure has caused her symptoms to become symptomatic. There does not appear to be any other major issues that I uncovered during my limited history and physical examination." (Ex. 18).

Claimant's attorney wrote to Dr. Phipps on June 4, 1998, asking some questions on causation. Claimant's attorney explained that in August 1997 claimant "went to work for [the employer] as a meat cutter." (Ex. 20). Claimant's attorney said that claimant worked overtime hours, which included one shift a week where she would close the meat cutting department and wash down the operation with a pressurized hose. (*Id.*)

On June 5, 1998, Dr. Phipps reported that claimant's history of obesity played only a minor role in the development of CTS. (Ex. 21). He felt that the association between obesity and CTS was relatively weak, and was likely an "unimportant factor when compared to a several year history of meat cutting." (*Id.*) He said that claimant's hypertension and use of birth control pills were even less significant. (*Id.*) Dr. Phipps explained:

> "The major cause for this woman's carpal tunnel syndrome is the cumulative occupational factors of working in meat cutting since 1990. Her work at [the employer] was a portion of that exposure and may have been more significant in that her duties may have been more hand intensive. Certainly, the work exposure at [the employer] was a last injurious exposure and appears to have led to her need for treatment." (*Id.*)

For the following reasons, we find that Dr. Phipps had an inaccurate history of claimant's job activities. Dr. Phipps consistently referred to claimant's work as a "meat cutter." (Exs. 12, 18, 21). In contrast, claimant explained that she was not a "meatcutter" who had served an apprenticeship in order to qualify in that occupation. (Tr. 28). She agreed that other employees performed that function. (*Id.*) She testified that she would occasionally do some meat cutting if a sale item ran out or if she was asked to do so by the manager. (*Id.*)

Claimant began working for the employer in August 1997 and her job title was a customer service clerk. (Tr. 10). She testified that she spent approximately one hour each day cutting meat. (Tr. 10, 11). Her job duties involved wrapping meat, which took approximately two to three hours per day. (Tr. 11, 12). She also waited on customers and occasionally used a meat grinder. (Tr. 12-14). Her work involved "prepping" specialty products, which included slicing vegetables and meats. (Tr. 13). Claimant's "prep" work took approximately three to four hours a day. (Tr. 14). She was also responsible for cleaning the meat department three to five times a week, which involved the use of a heavy-duty hose. (Tr. 15, 16).

Before working for the employer, claimant worked at a seafood customer service counter and she spent three to four hours a day cutting fish. (Tr. 17-18). Before that job, she was a fish department supervisor. (Tr. 18). That position involved fish cutting, some meat cutting and "prepping." (Tr. 19). She also worked in the fish department in another store. (Tr. 20). Claimant said she had worked in this general type of work since 1988. (Tr. 22). She had also performed some janitorial work. (Tr. 22, 23).

Based on claimant's testimony, cutting meat or fish has constituted only a portion of her job duties since 1988 and, in fact, other people performed the official "meatcutting" function. Nevertheless, Dr. Phipps' causation opinion was based on his understanding that she had worked as a "meat cutter" since 1990. (Ex. 18, 21). We are not persuaded that Dr. Phipps had an accurate understanding of claimant's work activities. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions based on an inaccurate history entitled to little or no weight).

Furthermore, Dr. Phipps' opinion is not persuasive because it lacks adequate explanation. Even if we assume that claimant was a "meat cutter," he did not explain how or why the activities she performed actually caused bilateral CTS, nor did he explain why claimant's symptoms were worse on her non-dominant left side.

Claimant has the burden of proving that an injury or occupational disease is compensable. ORS 656.266. We are not persuaded by Dr. Phipps' opinion because it is conclusory and based on an inaccurate understanding of claimant's work activities. There are no other medical opinions that support compensability. Dr. Duff, who examined claimant on behalf of the insurer, concluded that "constitutional" factors, such as obesity, hypertension and claimant's age and sex, were more important in developing CTS than her work exposure. (Ex. 16-5). Dr. Duff explained that the fact that claimant's symptoms were more severe in her nondominant hand suggested that occupational factors were not the most important. (*Id.*) Dr. Vigeland, claimant's treating physician, concurred with Dr. Duff's report. (Ex. 17). In sum, we conclude that claimant has failed to sustain her burden of proving compensability of her bilateral CTS condition.

ORDER

The ALJ's order dated September 3, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
VIRGINIA L. SCHULTZ, Claimant
WCB Case No. 96-03789
ORDER ON REMAND
Welch, Bruun & Green, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is pending before the Board on remand from the Court of Appeals. Pursuant to the court's December 24, 1998 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable between them.

Pursuant to the settlement, claimant stipulates that the insurer's denial, as supplemented by the agreement, "shall forever remain in full force and effect." In addition, the settlement provides that "the Request for Hearing shall be 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.

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[1] Based on the "reservation of rights" provision which acknowledges that claimant retains rights insofar as they "may be related to the original accepted claim" (which is required by OAR 438-009-0010(3), when resolving a dispute regarding an aggravation or partial denial) and the inclusion of the attorney fee awards previously granted by the Administrative Law Judge (ALJ) and Board orders that found claimant's combined porphyria condition compensable, we have interpreted the parties' settlement as resolving the compensability of claimant's current conditions (headaches, chronic fatigue syndrome, odor-related annoyance symptoms, chronic depression and combined porphyria condition) and not an attempt to overturn or vacate the previous compensability decisions rendered by the ALJ and Board.

In the Matter of the Compensation of
EVA M. SMITH, Claimant
WCB Case No. 98-03793
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that awarded claimant's attorney an assessed fee of $3,500 for services at hearing. In her brief on review, claimant requests that we increase the assessed fee awarded by the ALJ. On review, the issue is attorney fees.

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

Claimant is entitled to a reasonable assessed fee for services at hearing in prevailing over SAIF's denial of her occupational disease claim for a left knee condition. 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 did not submit a statement of services or make any specific attorney fee request. The ALJ awarded claimant's attorney an assessed fee of $3,500 for services at hearing in setting aside SAIF's denial. But 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 make any specific arguments regarding the factors provided by OAR 438-015-0010(4), nor does SAIF argue that the $3,500 fee awarded by the ALJ is "necessarily excessive," although it contends that the fee "may indeed constitute an excessive fee." Reply Brief, page 2. 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.

We recently rejected this same argument in *Daryl L. Underwood*, 50 Van Natta 2330 (1998). In *Underwood*, relying on *Russell L. Martin*, 50 Van Natta 313 (1998), and the Court's reconsideration of its decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or at 188-89, we concluded 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. We determined that, 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. *See Turnbow v. K.E. Enterprises, Inc.*, 155 Or App 59 (1998) (citing *McCarthy* for its holding "that, standing

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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."

alone, the absence of explanatory findings under ORS 20.075 to support an award or a denial of attorney fees is not a ground for reversal and that a court need only address the objections under the statute that are material to its decision"); *see also Wright v. Jones*, 155 Or App 249 (1998) (same).

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 stated in his order language that SAIF "shall pay claimant's attorney an assessed fee of $3,500 for his services in setting aside its denial." 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 $3,500 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; claimant was the only witness to testify. The record consists of ten exhibits, all of which were submitted by SAIF. Claimant's attorney generated no exhibits.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average complexity. The value of the interest and benefit secured were above average, in that claimant has obtained benefits for the chondromalacia patella condition. 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 $3,500, 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. We further note that claimant is not entitled to an attorney fee on review for her counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

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

In the Matter of the Compensation of
BARBARA M. JOHNSON, Claimant
Own Motion No. 98-0045M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 7, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from March 27, 1998 through September 2, 1998. SAIF declared claimant medically stationary as of September 2, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 7, 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 September 2, 1998 medical report, Dr. Bishop, claimant's attending physician, opined that claimant's left knee condition was healed and stable. In a September 28, 1998 "check-the-box" response, Dr. Bishop agreed that claimant was medically stationary as of September 2, 1998.[1] Based on Dr. Bishop's unrebutted medical opinion, it would appear that claimant was medically stationary on September 2, 1998. However, the determinative issue is whether claimant's compensable condition was medically stationary on October 7, 1998 to when SAIF issued its Notice of Closure.[2] Based on Dr. Bishop's November 10, 1998 opinion, we conclude that claimant's condition was not medically stationary at claim closure.

Dr. Bishop's most recent "check-the-box" response confirms that claimant was hospitalized from October 3, 1998 through October 13, 1998. During that hospitalization, she underwent a left knee aspiration. Determining that the hospitalization and treatment were causally related to claimant's accepted injury, Dr. Bishop concluded that she was not medically stationary on October 7, 1998, when SAIF closed her claim.

In light of Dr. Bishop's unrebutted opinion, we are persuaded that claimant's compensable left knee condition was not medically stationary on October 7, 1998. Accordingly, we set aside SAIF's October 7, 1998 Notice of Closure as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] SAIF attached an affidavit prepared by an adjuster attesting to a November 7, 1998 phone call from "Maureen" at Dr. Bishop's office that "affirmed" that claimant was medically stationary as of September 2, 1998. Inasmuch as our review on this "medically stationary" question is confined to medical evidence, we give no probative weight to any portion of this submitted affidavit.

[2] We have previously found that no "worsening" of a compensable injury is required to establish a non-medically stationary status in a reopened claim. *See Christi L. McCorkle*, 48 Van Natta 1766 (1996). Here, although we concluded that Dr. Bishop had declared claimant medically stationary on September 2, 1998, that date is not the relevant inquiry for the purposes of premature closure. *See Larry R. Comer*, 47 Van Natta 1574 (1995). Dr. Bishop opined that claimant was not medically stationary on October 7, 1998, the date that claimant's claim was closed. Furthermore, under the facts of this particular case, because claimant's claim was in reopened status at the time her condition required hospitalization, claimant needs to establish that she was not medically stationary at claim closure.

In the Matter of the Compensation of
TERRI A. BRIGGS-TRIPP, Claimant
Own Motion No. 94-0730M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Foster A. Glass, Claimant Attorney

Claimant requests review of the self-insured employer's September 15, 1998 Notice of Closure, which closed her claim with an award of temporary disability compensation from November 28, 1994 through April 1, 1998. The employer declared claimant medically stationary as of April 1, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

FINDINGS OF FACT

On December 14, 1994, we issued our Own Motion Order which authorized the payment of temporary disability compensation beginning November 28, 1994, the date claimant underwent surgery. Subsequent to her initial surgery, claimant's condition did not improve and she was in constant pain. In 1995 she sought treatment with Dr. Higdon, her new attending physician, who fitted her with upper and lower partial dentures and performed regular adjustments.

In February of 1998, Dr. Higdon felt that claimant required further surgery (*i.e.* endosseous implants). However, due to claimant's smoking habit and her addiction to narcotic pain medication, he would not consider surgery unless claimant abstained from smoking and remained free of narcotics for at least six months. To that end, Dr. Higdon referred claimant to a pain center for assistance in controlling her pain other than by narcotic medication.

Claimant completed her pain center treatment on April 1, 1998. Finding her medically stationary, the pain center physicians released her to full work. They also scheduled several follow-up appointments to monitor claimant's nicotine and narcotic use, recommending that she follow-up with Dr. Higdon on a monthly basis for at least six months. Dr. Higdon concurred with the pain center's discharge report.

On September 15, 1998, the employer issued its Notice of Closure. Claimant was declared medically stationary as of April 1, 1998.

In an October 2, 1998 medical report, Dr. Higdon opined that sufficient time had elapsed and that claimant needed the dental implant surgery he had previously 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 September 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 employer relies on the pain center's discharge report and Dr. Higdon's "check-the box" concurrence. However, that report and Dr. Higdon's concurrence relate to claimant's condition over five months prior to the date the employer closed the claim.

Shortly after the September 15, 1998 claim closure, Dr. Higdon authored an October 2, 1998 report that offers a different opinion regarding claimant's medically stationary status at the time of claim closure. Dr. Higdon explained that he had recognized the need for implant surgery prior to her entering the pain center. However, he agreed that she was medically stationary in April of 1998, because surgery at that time would not be considered until sufficient time had elapsed to allow claimant to get her chronic pain under control.

Dr. Higdon further explained that it had become "more obvious that the dental implants would need to be placed if there was any hope of achieving the occlusal support needed to control the pain. *** I have continued to see [claimant] and, in spite of my having agreed to forego the dental implants for several months, I now feel strongly that it is imperative that these implants be placed at the earliest time possible." Finally, Dr. Higdon noted that he referred claimant to Dr. Judy who does implant surgery. Dr. Judy has already gone ahead with tissue grafting in preparation for the needed implant 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. Higdon has opined that claimant still requires the dental implant surgery that was first recommended in early 1998. The surgery recommended by Dr. Higdon is designed to materially improve claimant's compensable injury. That surgery was postponed to allow claimant some time to get her chronic pain under control.

Having treated claimant on a monthly basis since she was discharged from the pain center in April 1998, Dr. Higdon is in the best position to offer an opinion as to claimant's medically stationary status at the time of closure. Dr. Higdon's October 2, 1998 opinion was based on medical examinations conducted monthly, and authored less than two weeks after the employer closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the September 15, 1998 claim closure and Dr. Higdon's October 1998 report, we conclude that Dr. Higdon's October 1998 opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622.[1]

Under such circumstances, we conclude that claimant was not medically stationary on September 15, 1998 when her claim was closed by the employer. Accordingly, we set aside the Notice of Closure as premature and remand the claim to the employer for further processing in accordance with law. When appropriate, the claim shall be closed by employer pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] In light of Dr. Higdon's original opinion expressed in his one word "check-the-box" concurrence with the pain center's April 1998 discharge report, the October 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).

In the Matter of the Compensation of
JACK F. STEWART, Claimant
Own Motion No. 98-0515M
OWN MOTION ORDER DENYING CONSENT TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Welch, Bruun, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The Benefits Section of the Workers' Compensation Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1988 injury claim with the SAIF Corporation expired December 8, 1994. 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.*

Here, on March 14, 1991, the Board approved the parties' Claim Disposition Agreement (CDA), whereby claimant released his rights to the following workers' compensation benefits: all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and "Own Motion" rights per ORS 656.278 in claim number 7716530D, and all other workers' compensation benefits except compensable medical services under ORS 656.245.

Claimant's aggravation rights on his 1988 injury claim have expired, thus placing the claim in Own Motion status. ORS 656.273(4); ORS 656.278(1)(a). Furthermore, because of the March 1991 CDA , claimant specifically released his own motion benefits under ORS 656.278 and temporary disability compensation rights, his entitlement to any further temporary disability under his 1988 injury claim has been extinguished. *See* ORS 656.236(1)(a); *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

Inasmuch as claimant's entitlement to further temporary disability compensation under his 1988 claim has been released, the Board is without authority to consent to an order designating a paying agent for the purposes of temporary disability compensation. However, because 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.

January 8, 1999 Cite as 51 Van Natta 23 (1999)

In the Matter of the Compensation of
MELVIN L. WALL, Claimant
Own Motion No. 98-0494M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right leg condition. Claimant's aggravation rights expired on August 25, 1985. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) it is unknown whether surgery or hospitalization is reasonable and necessary.

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

For the purposes of reopening under our own motion authority, we define surgery as an invasive procedure which is undertaken for a curative purpose. *See Fred E. Smith*, 42 Van Natta 1538 (1990). In addition, hospitalization is defined as a nondiagnostic procedure that requires an overnight stay in a hospital or similar facility. *See, e.g., Roger D. Jobe*, 41 Van Natta 1506 (1989).

Here, the record contains an October 22, 1998 Emergency Department Record which demonstrates claimant's admittance physical and history work-up by Dr. Peretta. Claimant was given intravenous antibiotics and advised to follow-up his care on an outpatient basis. Dr. Peretta discharged claimant from the emergency department in an improved condition.

Because claimant had been admitted for emergency treatment and discharged that same day, that treatment does not constitute hospitalization. *See Daniel P. Moore*, 46 Van Natta 2490 (1994); *Fred E. Smith*, 42 Van Natta at 1538. Furthermore, although the administration of intravenous antibiotics may have improved claimant's current condition, it does not qualify as "surgery" within the meaning of ORS 656.278(1)(a). *See generally John Denton*, 50 Van Natta 1073 (1998); *Tamera Frolander*, 45 Van Natta 968 (1993).

Inasmuch as claimant's emergency room visit does not qualify as "hospitalization" and the record fails to demonstrate that claimant requires surgery, we are not authorized to grant claimant's request to reopen the claim. Accordingly, we deny the request for own motion relief. *Id.*

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

IT IS SO ORDERED.

In the Matter of the Compensation of
FREDERICK C. DULLEY, Claimant
WCB Case No. 97-05458
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral hearing loss. On review, the issues are compensability and (potentially) responsibility. We affirm.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first full paragraph on page 2, we delete the portion of the paragraph after the first two sentences. We delete the second full paragraph on page 2. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was 59 years old at hearing. Since age 18, he had been exposed to noise at his work for various employers. In 1975, he began working for the employer at a plywood manufacturing facility. He filed a claim for bilateral hearing loss with the employer in December 1996. (Ex. 1).

The ALJ found that, because claimant did not join other employers in the proceeding, he could not invoke the last injurious exposure rule and could not argue causation based on the "totality" of work exposure. The ALJ concluded that claimant failed to prove compensability of his bilateral hearing loss.

Citing *Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998), claimant relies on the last injurious exposure rule to argue that his bilateral hearing loss is work-related. In *Gosda*, the court concluded that last injurious exposure rule of proof is applicable in any case in which the evidence supports its application. *Id.* at 126. The rule of proof need not be brought into a case by a claimant through a pleading or argument. The court concluded that the Board should have applied the last injurious exposure rule of proof because the medical evidence indicated that the claimant's work exposure (as a whole) caused his carpal tunnel syndrome.

Here, claimant began working at age 18 in another plywood mill for a short time. (Tr. 7). He then worked "off and on for different logging at gyppo loggers setting chokers." (*Id.*) He worked for "CR & K" for 13 years. (*Id.*) Claimant was the "hook tender" and did the hiring and firing. (*Id.*) He occasionally worked with chainsaws. (*Id.*)

Claimant began working for the employer in 1975. (Tr. 8). He started out doing "cleanup" around the presses for a few months. (Tr. 8-9). For the next year and a half to two years, he worked in the main part of the plant running saws. (Tr. 10). For the past 20 years, claimant has been a scrubber operator. (Tr. 10). The scrubber machinery is located by the boiler room and he spends 70 to 80 percent of his time in and around the boiler room. (Tr. 10-11). Claimant testified that it was noisier inside the boiler room. (Tr. 11). He did not begin wearing ear protection until approximately 1988. (Tr. 12).

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[1] We modify the ALJ's order to note that Exhibits 1 through 8 and OA were admitted in evidence.

To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of his bilateral hearing loss. 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).

This is the initial claim for claimant's bilateral hearing loss. There is no evidence in the record that claimant had a preexisting hearing loss condition at the time he began working at age 18. Therefore, we conclude that there is no "preexisting" hearing loss condition. 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. *See New Portland Meadows v. Dieringer*, 153 Or App 383, *on recon* 157 Or App 619 (1998). Thus, to establish the compensability of his bilateral hearing loss condition under ORS 656.802(2)(a), claimant must prove that his employment conditions were the major contributing cause of that condition.

Because of claimant's multiple work exposures and the number of potential causes of the hearing loss, the causation issue presents a complex medical question requiring competent medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993).

There are two expert opinions on causation. Both experts focused on the causation of claimant's hearing loss from 1975 to 1997 rather than the causation of his hearing loss during his entire employment. Both Dr. Lee, claimant's treating physician, and Dr. Ediger, audiologist, agreed that claimant had significant hearing loss at the time of his first hearing test in 1975, before he started working for the employer. Dr. Lee said that the 1975 audiogram, which was taken at the time of claimant's employment with the employer, represented a "significant" loss of hearing in the higher frequency response. (Ex. 9-1). In a later report, Dr. Lee reiterated that claimant had a "very significant noise exposure" in his employment in the timber industry before 1975. (Ex. 12-1).

Dr. Ediger reported that claimant "undoubtedly worked around excessively high noise levels" before his employment with the employer. (Ex. 6-4). In a January 8, 1998 report, Dr. Ediger said that both he and Dr. Lee agreed that claimant's 1975 baseline hearing test showed that he had a "very significant hearing loss" before working for the employer. (Ex. 10-1).

Although the opinions of Drs. Lee and Ediger indicate that claimant's work-related noise exposure before 1975 may have been the major contributing cause of his bilateral hearing loss in 1975, neither one of them addressed the critical issue in this case, *i.e.*, whether or not claimant's work activities during his entire employment were the major contributing cause of his current bilateral hearing loss. Moreover, when their reports are read as a whole, they are not sufficient to sustain claimant's burden of proof.

For the following reasons, we are not persuaded by Dr. Lee's opinion. In his October 24, 1997 report, Dr. Lee indicated that claimant had a significant hearing loss when he began working for the employer and that loss "markedly worsened during the time he was there." (Ex. 9-1). Nevertheless, he commented that "[t]o say 51% is difficult," but he felt claimant's hearing loss had progressed while working for the employer. (*Id.*) In the same report, however, Dr. Lee indicated that, factoring in presbycusis, claimant's hearing had *improved* since working for the employer. Dr. Lee referred to the summary of audiometric test results prepared by Dr. Ediger, which indicated that in 1975 claimant had 9.75 percent hearing loss in his left ear and 11.16 percent in his right ear. (Ex. 9-1). Dr. Lee explained: "If you then follow the percentages down to 1997, you will see that he has *actually improved his hearing working at [the employer]* because he now has a 7.25% hearing loss in his left and 8.34% loss in his right." (*Id.*; emphasis added). Thus, although Dr. Lee felt that claimant's hearing loss had worsened while working for the employer, he acknowledged that, when presbycusis was considered, claimant's hearing improved during that time period.

In a later report on February 13, 1998, Dr. Lee referred to Dr. Ediger's chart that compared claimant's audiometric test results to the expected presbycusis elements. Dr. Lee said that, by comparing the loss pattern, claimant's hearing loss had increased from the 1980's where it was an 11% loss, to the 1990's, where he had a 20% loss. (Ex. 12-2). Dr. Lee concluded that these figures, which considered the factors of presbycusis, still represented a minimum 10% progressive loss in both ears. (*Id.*) That figure is insufficient to establish "major contributing cause."

Dr. Ediger, however, pointed out that Dr. Lee was comparing the 1994 test to the 1975 test, but had not compared the 1975 test to the 1997 test. Dr. Ediger agreed that a comparison of the 1975 "percentage combined binaural loss" to that of 1994 indicated there was a 10 percent increase in hearing loss beyond that expected because of presbycusis. (Ex. 13-1). On the other hand, if the 1975 test is compared to either the September 1992 test or the June 1997 test, there has been no increase in hearing loss. (*Id.*) Dr. Ediger explained that from 1975 to 1994, presbycusis accounted for 55 percent of hearing decline in claimant's left ear and 97 percent in the right ear. (*Id.*) He reported further: "Using the same approach, presbycusis accounted for 67% of the left ear hearing decline and 100% of the right ear hearing decline in the 1996 test, and 100% of hearing decline for both ears using the 1997 test." (*Id.*)

Thus, Dr. Ediger's reports establish that between 1975 and 1997, claimant has had no increase in hearing loss beyond that expected because of presbycusis. (Exs. 10, 13). In other words, presbycusis accounted for all of claimant's hearing decline between 1975 and 1997. (Ex. 13-1). Because Dr. Lee's report referring to claimant's hearing loss in the "1990's" did not compare claimant's hearing loss results to his *current* hearing loss, we do not find his report persuasive.

Furthermore, we are not persuaded by Dr. Lee's conclusion that claimant had a significant problem with speech discrimination (the ability to separate sounds). (Ex. 12-2). Dr. Ediger explained that his 1997 test showed good speech discrimination ability. (Ex. 13-2). Dr. Ediger noted that, in any event, poor speech discrimination can result from many causes, including presbycusis. (*Id.*)

Claimant has the burden of proving that his bilateral hearing loss condition is compensable by a preponderance of the medical evidence. ORS 656.266. Although the opinions of Drs. Lee and Ediger indicate that claimant's work-related noise exposure before 1975 may have been the major contributing cause of his bilateral hearing loss in 1975, neither of them addressed whether claimant's work activities during his entire employment were the major contributing cause of his bilateral hearing loss. Dr. Lee's opinion is not sufficient to establish that claimant's employment conditions were the major contributing cause of his hearing loss between 1975 to 1994, particularly in light of his statement that when presbycusis is considered, claimant actually improved his hearing working at the employer. (Ex. 9-1). Rather, we are more persuaded by Dr. Ediger, who concluded that between 1975 and 1997, claimant has had no increase in hearing loss beyond that expected because of presbycusis. (Exs. 10, 13). Moreover, although it is well settled that "magic words" are not necessary to establish medical causation, *see Freightliner Corp. v. Arnold*, 142 Or App 98 (1996), neither Dr. Lee's nor Dr. Ediger's reports are sufficient to establish that claimant's work activities *as a whole* were the major contributing cause of his current hearing loss.

Finally, we address claimant's alternative argument that presbycusis should not be included in the equation to determine major causation. In *Henry F. Downs*, 48 Van Natta 2094, *on recon* 48 Van Natta 2200 (1996), the claimant filed an occupational disease claim for bilateral hearing loss after retiring from 33 years of employment at a box factory. The claimant argued that his binaural hearing loss at retirement, after adjusting for presbycusis, was due to noise exposure during his work for the employer. We found that the persuasive medical evidence established that the major contributing cause of the claimant's bilateral hearing loss condition was presbycusis, not work-related exposure. Furthermore, we found that the claimant was not permitted to extract a portion of the hearing loss and claim that only that portion was caused in major part by work exposure. 48 Van Natta at 2096. Rather, under ORS 656.802(2)(a), the claimant must prove that the major contributing cause of his *overall hearing loss* was work-related noise exposure. *Id.*

We reach the same conclusion in the present case. Although the expert opinions discussed the contribution of presbycusis to claimant's hearing loss since 1975, none of the opinions analyzed the contribution of presbycusis to claimant's overall hearing loss during his entire employment. Neither of the medical opinions establishes that claimant's employment conditions were the major contributing cause of his current bilateral hearing loss condition. Under these circumstances, we conclude that claimant has failed to sustain his burden of proving compensability.

ORDER

The ALJ's order dated July 29, 1998 is affirmed.

In the Matter of the Compensation of
DONNA A. GOODMAN-HERRON, Claimant
WCB Case No. 94-09926
SECOND ORDER ON REMAND
Daniel Snyder, Claimant Attorney
David L. Runner (Saif), Defense Attorney

On November 27, 1998, we abated our October 30, 1998 Order on Remand that set aside the SAIF Corporation's denial of claimant's claim for a psychological disorder. We took this action to consider SAIF's motion for reconsideration, which challenges our decision to adopt the Administrative Law Judge's (ALJ's) finding that claimant was sexually assaulted by her co-worker.

On reconsideration, SAIF argues that claimant's testimony concerning the incident was implausible and that she was not credible. SAIF also asserts that, notwithstanding the ALJ's specific finding that claimant's testimony was credible, the Board has a duty to make its own determination regarding claimant's credibility and to adequately explain that determination in the order.

As set forth in the order on remand, we made our own determination as to claimant's credibility. After a *de novo* review of the record, we accepted the ALJ's credibility finding and concluded that claimant was, in fact, sexually assaulted by Hirsch. But, contrary to SAIF's contention, we are not required to explain the reasons for our determination. *See, e.g. Erck v. Brown Oldsmobile*, 311 Or 519, 525 (1990) (the Board's statutory charge is to affirm, reverse, modify or supplement the order of the ALJ and make such disposition of the case as it determines to be appropriate; even where the Board elects to disregard an ALJ's express credibility finding, it is not required to explain its reasons for doing so).

As a general rule, the Board will generally defer to the ALJ's determination of credibility. *See Erck v. Brown Oldsmobile*, 311 Or at 525-26. The reason for this deference is simple: Unlike us, the ALJ has the opportunity to observe the demeanor of the claimant and other witnesses who testify at the hearing. Indeed, in *Ryf v. Hoffman Construction Co.*, 254 Or. 624, 631 (1969), the Oregon Supreme Court--on *de novo* review of a workers' compensation award--explained: "[W]e * * * have to give some weight to the fact that the Hearing Officer, and he alone, has the opportunity to observe the claimant and other witnesses, a factor which we have regarded as highly significant in reviewing other cases on appeal." *See also Haines Com'l Equip. Co. v. Butler*, 268 Or. 660, 664, (1974) ("we accord great weight to [a trial court's findings of fact] when, as in this case, the testimony was conflicting"); *Bragger v. Oregon Trail Savings*, 275 Or. 219, 221 (1976) ("[t]he trial judge is in a much better position to assess the credibility of the witnesses than is this court and his conclusion * * * is entitled to considerable weight").

In this case, the ALJ acknowledged that the testimony was conflicting and that the credibility issue was of primary importance. He explained that because claimant and Hirsch were the only two people in claimant's hotel room at the time, the answer (as to whether claimant was sexually assaulted by Hirsch) depended upon whose testimony was believed. The ALJ then found as follows:

> "Thirty-three witnesses, including claimant and Hirsch, testified, and a number of exhibits were offered in this endeavor. Having considered all of the testimony and exhibits received in evidence, having observed the demeanor and manner of witnesses, I conclude that claimant's testimony concerning the sexual assault and subsequent sexual harassment by Hirsch is credible."

In reviewing the record on remand, we found nothing in the substance of the witnesses' testimony to persuade us that the sexual assault did not, in fact, occur. *Compare Gail A. Albro*, 48 Van Natta 41 (1996) (inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if the inconsistencies raise such doubt that we are unable to conclude that material testimony is credible). From an objective standpoint, claimant's testimony concerning the events of the night in question impresses us as more credible than that of Hirsch. SAIF's various challenges to the plausability of claimant's testimony and its allegations as to claimant's motivation for filing a criminal complaint against Hirsch are speculative and do not persuade us that claimant's testimony was false or

unreliable.[1] Consequently, we adhere to our original determination that Hirsch sexually assaulted and harassed claimant.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to SAIF's motion), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 30, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In its brief on remand, SAIF conceded that some of Hirsch's testimony concerning the incident in question was incredible. SAIF argues, however, that we should not accept either account of the encounter, and conclude that, to the extent anything occurred between claimant and Hirsch, it was consensual. We find no evidence to support this theory, and reject it.

In the Matter of the Compensation of
PEGGY EVENHUS, Claimant
WCB Case No. C8-03001
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Shelley K. Edling, Claimant Attorney
Barbara Woodford, Defense Attorney

Reviewed by Board Members Biehl and Moller.

On December 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 the compensable injury. We approve the proposed disposition.

On page 2, number 7, the agreement provides;

> "The claim was accepted as nondisabling and was closed by the Notice of Claim Acceptance on February 18, 1997 pursuant to ORS 656.268(3)."

We have previously held that, whether the claim has been accepted as disabling or nondisabling, a notice of acceptance does not constitute closure of a claim. *See Janna Bailey,* 50 Van Natta 1474 (1998). Thus, we interpret the CDA as providing that the claim has never been closed. In any event, we find that the agreement satisfies OAR 438-009-0022(4)(b) (CDA must give a date of the first claim closure, if any).

As interpreted herein, we conclude that the parties' agreement is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
STEPHEN GORDON, Claimant
WCB Case No. 98-02590
ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests abatement and reconsideration of that portion of our December 21, 1998 Order on Review that awarded an assessed attorney fee of $750 for services at hearing and on review for prevailing over the insurer's denial of claimant's left wrist sprain. The insurer has responded, asserting that the attorney fee is appropriate.

The insurer first accepted a claim for "left navicular fracture" and then revoked the acceptance and denied the claim. On review, we agreed with the ALJ that the "back-up" denial was procedurally valid. We also decided that the insurer proved that the left navicular fracture condition was not compensable.

We further found, however, that claimant proved that he sustained a left wrist sprain and that the condition was caused by a work injury. Thus, we set aside the insurer's denial only with regard to the left wrist sprain and awarded an assessed fee of $750 for claimant's counsel's services at hearing and on review in prevailing over this portion of the denial.

In moving for reconsideration, claimant's attorney contends that the attorney fee award should be increased to $2,000. Although claimant notes that he is "mindful" that the Board did not set aside the "back-up" denial and he prevailed only over the denial for the left wrist sprain, he argues that the length of the hearing, the solicitation of medical reports, and other factors listed in OAR 438-015-0010(4) support a greater attorney fee award. The insurer responds that the Board's attorney fee award is appropriate in view of the limited benefits secured.

In determining a reasonable attorney fee, we consider the following factors: (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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, as noted by claimant's attorney, the hearing lasted approximately one and one-half hours. The record consisted of 15 exhibits, including one medical report generated at claimant's attorney's request. On review, claimant's attorney submitted a 5-page appellant's brief and 5-page reply brief.

As discussed above, the primary issue at hearing and on review was the procedural validity of the "back-up" denial. In particular, the insurer argued that claimant had materially misrepresented his medical history. Thus, part of claimant's testimony at hearing addressed whether he had previously injured his left wrist and then misrepresented such information when he filed his claim and sought treatment. A portion of the record also consisted of medical reports from claimant's previous left wrist injury. On review, the bulk of claimant's briefs was devoted to the "back-up" denial issue.

For these reasons, we find that the time devoted to the issue of the compensability of the left wrist sprain is small. Furthermore, the record shows that the benefit secured and the value of the interest in proving compensability of this condition also is small; claimant's treating physician reported that the left wrist sprain had resolved and his current need for treatment (including surgery) is solely due to a preexisting condition.

Moreover, the compensability issue was of below average complexity. There was some risk that claimant's attorney would go uncompensated concerning this issue; both attorneys were skillful; and there was no assertion of frivolous issues or defenses.

After conducting our reconsideration and after considering these factors, especially the limited time devoted to the issue and the small benefit secured, we find that $1,500 is a reasonable attorney fee for services at hearing and on review in prevailing over the insurer's denial of the left wrist sprain. Consequently, we modify our prior attorney fee award.

Accordingly, we withdraw our December 21, 1998 order. On reconsideration, as modified herein, we adhere to and republish our December 21, 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
DANIEL L. PASSON, Claimant
WCB Case No. 97-07535
SECOND ORDER OF DISMISSAL
James B. Northrop (Saif), Defense Attorney

On January 7, 1999, the Board received claimant's response to its December 15, 1998 Order of Dismissal. We interpret claimant's correspondence as a request for reconsideration. After considering claimant's request, we continue to find that the record does not establish that the Board received a timely request for review within 30 days of the Administrative Law Judge's May 18, 1998 order.

In our Order of Dismissal, we found that, 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 (who is *pro se*) to the Board requesting review of the ALJ's order.

We explained that, although the May 29, 1998 letter was *dated* within 30 days of the ALJ's May 18, 1998 order, the record failed to show that the Board *received* the request prior to expiration of the statutory 30-day period. Instead, the Board's first receipt of the letter occurred on December 2, 1998, when it received the May 29, 1998 letter along with SAIF's November 30, 1998 letter. Consequently, we concluded that the record did not establish that claimant filed a request for review prior to the expiration of the statutory appeal period. Furthermore, considering the November 30, 1998, correspondence as a request for review, claimant's filing was untimely. Therefore, we decided that we lacked jurisdiction to review the ALJ's order and dismissed claimant's request for Board review.

In his December 30, 1998 letter, claimant states that he is "shocked at these tactics" and expresses disbelief that the Board did not receive his May 29, 1998 letter requesting Board review. According to claimant, the "letter was sent to all parties involved" and he is "still requesting a review by the board."

We find claimant's letter insufficient to show that he either mailed or hand-delivered his request for review to the Board within 30 days of the ALJ's May 18, 1998 order. In particular, claimant only asserts that he sent the letter "to all parties involved," without specifically explaining that delivery of the request was timely or providing other evidence, such as a receipt for certified or registered mail. Consequently, we continue to conclude that claimant did not timely file a request for review and we lack jurisdiction to review the ALJ's order.[1]

Accordingly, we withdraw our December 15, 1998 order. On reconsideration, as supplemented, we republish our December 15, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] As noted in our prior order, if claimant has information proving that he timely mailed or delivered his request for review to the Board, he may submit such evidence for our review. Because our authority to reconsider this order expires 30 days after the date of this order, he should submit this information as soon as possible.

In the Matter of the Compensation of
DOROTHY DICKINSON, Claimant
WCB Case No. 97-07047
ORDER ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of our December 17, 1998 order that reduced claimant's assessed attorney fee from $9,500, as awarded by an Administrative Law Judge (ALJ), to $7,500. The insurer opposes claimant's request.[1]

Claimant contends that our fee award is unsupported by our findings and that it amounts to an "excessively low hourly fee."

We note at the outset that "time devoted to the case" (here, 67 hours) is but one of the factors we consider in determining a reasonable attorney fee. *See Danny G. Luehrs*, 45 Van Natta 889, 890 (1993). Thus, because all relevant rule-based factors are considered in reaching our decision, our fee award should not be interpreted as setting an hourly fee.

Claimant argues that our findings do not support the fee awarded, because we found that the case involved issues of above average medical complexity; the value of the claim and the benefits secured for claimant were above average; there was a significant risk that claimant counsel's efforts might have gone uncompensated; and counsel presented claimant's position in a thorough, well-reasoned and skillful manner. Implicit in claimant's argument is a contention that the $7,500 fee awarded is not commensurate with the "above average," and "significant" and "quality-related" findings.

The $7,500 attorney fee constitutes a reasonable award, for the reasons expressed in our initial order. We considered *all* the rule-based factors in reaching this conclusion, noting the particular relevance of the factors individually mentioned in our decision. We also note that the fee award is well above average --in keeping with our findings-- when compared with most compensability disputes litigated before this forum.[2]

Accordingly, we withdraw our December 17, 1998 order. Having reconsidered the record and the parties' arguments, we adhere to and republish our December 17, 1998 order, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] The insurer's submission on reconsideration asserts only that claimant's request for reconsideration contains nothing substantive not previously raised.

[2] *See e.g., Pamela G. Frank*, 50 Van Natta 219 (1998); *Kim P. Nichols*, 50 Van Natta 102 (1998); *Karen Deaton, on remand* 49 Van Natta 1200 (1997); *Lois J. Schoch, on remand* 49 Van Natta 788 (1997).

In the Matter of the Compensation of
PETER GEVERS, Claimant
WCB Case No. 95-10971
ORDER ON REMAND (REMANDING TO APPELLATE UNIT)
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Gevers v. Roadrunner Construction*, 156 Or App 168 (1998). The court has reversed our prior order, *Peter Gevers*, 49 Van Natta 1228 (1997), that affirmed an Administrative Law Judge's (ALJ's) order that declined to award additional unscheduled permanent disability benefits for a left shoulder condition beyond the 74 percent (286.8 degrees) awarded by a prior order. Finding no evidence that claimant's loss of strength in his left shoulder was due to a specific named peripheral nerve, we declined to award permanent disability under *former* OAR 436-35-350(3) and (5) (WCD Admin. Order 6-1992).[1]

In reversing our order, the court found that, unlike subsection (3) of *former* OAR 436-35-350, subsection (5) does not require a showing of damage to a particular nerve for loss of shoulder strength to be ratable. The court has remanded the case 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). Alternatively, the court held that, if we determine that claimant's loss of strength is not ratable under the rule, we are required under ORS 656.726(3)(f)(C) to remand the case to the Director for adoption of a temporary rule to address claimant's increased disability.

We begin with a brief summary of the pertinent facts. In 1988, claimant compensably injured both shoulders in a fall from a scaffold. He underwent multiple surgeries and was declared medically stationary in November 1990. A February 1992 Determination Order awarded claimant 74 percent unscheduled permanent disability for his shoulders and 19 percent scheduled permanent disability for loss of use or function of the left arm. This award was affirmed by an April 24, 1992 Order on Reconsideration.

In December 1992, the insurer accepted a claim for aggravation of claimant's left shoulder. Claimant had two additional surgeries on that shoulder and was declared medically stationary in November 1994. An April 13, 1995 Determination Order awarded temporary disability but no additional permanent disability.

Claimant requested reconsideration. He was examined by a medical arbiter panel in September 1995, who found, among other things, that he displayed a marked decreased ability to repetitively use the left shoulder as well as a loss of strength in the shoulder. A September 15, 1995 Order on Reconsideration affirmed the Determination Order in all respects, finding that claimant had not established a permanent worsening.

Claimant requested a hearing, and the Order on Reconsideration was affirmed by a February 20, 1996 Opinion and Order. Claimant requested Board review. We affirmed, finding that claimant had not established unscheduled permanent disability in excess of the 74 percent award he received in 1992. *Peter Gevers*, 49 Van Natta at 1288. Claimant requested judicial review.

As set forth above, the court has directed us to consider whether claimant's loss of left shoulder strength is due to muscle loss or disruption of the musculotendinous unit and, if so, to value the loss under *former* OAR 436-35-350(5). The court further held that if we find that claimant's strength loss is *not* ratable under this rule, we are statutorily required to remand the case to the Director for adoption of a temporary rule to accommodate claimant's increased impairment. *Gevers v. Roadrunner Const.*, 156 Or App at 174.

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[1] *Former* OAR 436-35-330(19) provided that injuries resulting in loss of strength of the shoulder were ratable under *former* OAR 436-35-350(3) and (5). *Former* OAR 436-35-350(3) applied to "[i]njuries to a unilateral specific named peripheral nerve with resultant loss of strength." *Former* OAR 436-35-350(5) provided as follows:

> "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."

Claimant maintains that his loss of strength is due to a loss of muscle tissue and disruption of the musculotendinous unit of the left shoulder, and should therefore be valued as if *each* unilateral motor nerve of the left shoulder were impaired.[2] We find to the contrary.

The medical arbiters reported that claimant had 3+/5 strength about the left shoulder and that the decreased strength was due to "perijoint fibrosis and not to any one specific nerve muscle or tendon unit." We take administrative notice of the fact that the prefix "peri-" means "around" or "near" and the term "fibrosis" means the "formulation of fibrous tissue as a reparative or reactive process."[3] *See Stedman's Electronic Medical Dictionary,* 1998 (based on Stedman's Medical Dictionary, 26th ed.). Thus, the record establishes that claimant has a generalized loss of strength about the shoulder due to the formation of fibrous tissue. The arbiter's report does not, however, indicate that this fibrous tissue represents a loss of muscle, nor does it identify the particular muscles or tendons of the shoulder affected by claimant's injury or multiple surgeries. Because the medical evidence does not establish that this fibrous tissue is encompassed within the muscle or musclotendinous unit, we cannot rate claimant's "perijoint fibrosis" under the current standards.[4]

Because we have determined that claimant's 3+/5 strength due to perijoint fibrosis is not ratable under *former* OAR 436-35-350(5), we follow the court's instruction to remand the case to the Director, even though claimant has not requested such relief. *Gevers v. Roadrunner Const.*, 156 Or App at 174.

Accordingly, on reconsideration of our August 1, 1997 order, we vacate the ALJ's February 20, 1996 order. This matter is remanded to the Appellate Unit for the Workers' Compensation Division for further action consistent with the court's and this order.

IT IS SO ORDERED.

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[2] *Former* OAR 436-35-350(3) lists seven unilateral nerves affecting the shoulder joint--the accessory, anterior thoracic, axillary, dorsal scapular, long thoracic, subscapular and thoracodorsal--and establishes an impairment value for loss of each individual nerve.

[3] The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *See Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985). This includes the definition of medical terms. *See SAIF v. Calder*, 157 Or App 224 (1998).

[4] Furthermore, contrary to claimant's contention, the arbiters' determination that claimant's strength loss was not due to "any one specific nerve muscle or tendon unit" does not establish a strength loss due to every muscle or tendon of the shoulder. As we noted in our prior order, in the absence of supporting medical evidence, we were unwilling to infer an injury to a specific nerve for purposes of *former* OAR 436-35-350(3). Similarly, on this record, even if we were to assume that that the fibrous tissue about the shoulder represents a loss of muscle tissue, we cannot infer a loss or disruption to *every* muscle and musculotendinous unit of the left shoulder. Therefore, we cannot value claimant's strength loss under *former* OAR 436-35-350(5) as if *all* unilateral nerves were impaired.

In the Matter of the Compensation of
CRAIG A. McINTYRE, Claimant
WCB Case No. 97-09256
ORDER ON REVIEW
Lavis & DiBartolomeo, Claimant Attorneys
Zimmerman & Nielsen, 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 occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) assessed a $5,000 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

Claimant has worked as a metal fabricator and welder for about 17 years. He worked for the insured in August and September, 1996; from October 16, 1996 to January 31, 1997; and from February 19, 1997 to February 28, 1997. (*See* Exs. 2, 9; Tr. 8, 18-19). In the fall of 1996, claimant spent about 40 hours using a particularly vibratory heavy grinder to grind stainless steel seams for the insured. He experienced numbness and tingling in his arms during and after this project.

Claimant was self-employed as a mechanic after he stopped working for the insured in February 1997. His work activities were less hand-intensive, but his symptoms continued. Claimant first sought treatment for bilateral CTS in June 1997, while he was self-employed.

Claimant filed a claim with the insured. The insurer denied compensability and responsibility. Claimant requested a hearing.

The ALJ found the claim compensable, based on undisputed medical evidence that claimant's CTS was work-related.[1] The ALJ also found the insurer responsible, reasoning that claimant's later self-employment did not "worsen the condition independently." Opinion and Order, p. 6.

We note at the outset that ORS 656.308(1) is not applicable because there is no prior accepted compensable injury.[2] Consequently, we look to the last injurious exposure rule (LIER) to resolve this dispute.[3]

The insurer argues that responsibility should be assigned to claimant's self-employment, because claimant first sought medical treatment for his CTS while he was self-employed. *See United Parcel Service v. Likos*, 143 Or App 486 (1996). We agree, but the more precise question is whether the insurer may avoid "responsibility," based on evidence that claimant's self-employment contributed to his condition. On this record, the answer is yes.[4]

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[1] We agree that Dr. Wilson's opinion establishes that claimant's work activities for the employer were the major contributing cause of his CTS. (*See* Exs. 10-1, 11-2, 12-9-11). *See* ORS 656.802.

[2] *See Reynolds Metals v. Rogers*, 157 Or App 147 (1998); *SAIF v. Yokum*, 132 Or App 18, 23 (1994); *Roy D. Hodgkin*, 49 Van Natta 1279, 1281 (1997).

[3] The "independent contribution/pathological worsening" test applies when the issue is whether responsibility *shifts* to a subsequent carrier. *See* ORS 656.308(1). It does not apply here because the issue involves initial assignment, not shifting.

[4] "It is well established that [a carrier] * * * may assert the rule of responsibility as a defense even when a claimant has chosen to prove actual causation." *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 79 (1997) (citation and footnote omitted); *see Spurlock v. International Paper Co.*, 89 Or App 461, 464-65 (1988) (same) (*citing Runft v. SAIF*, 303 Or 493, 501-2).

There is undisputed medical evidence that claimant's self-employment contributed to his CTS. (*See* Exs. 8A-3-4, 12-10-11). That is sufficient to invoke defensive use of LIER "as a rule of responsibility." *Safeco Ins. Co. v. Victoria*, 154 Or App 574, 577 (1998). Under the rule, responsibility for claimant's CTS is initially assigned at the last potentially causal employment[5] -- in this case, the self-employment. *See Likos*, 143 Or App 486 (1996). Because the record does not establish that it was impossible for claimant's self-employment to cause his condition or that prior employment was its sole cause, responsibility remains with the self-employment. *See New Portland Meadows v. Dieringer*, 153 Or App 383, 390 (1998); *Multnomah County School Dist. v. Tigner*, 113 Or App 405, 407 (1992) (If conditions at the assigned employment "actually contributed" to the claimant's disease, the insurer on the risk at that time cannot avoid responsibility).

In short, the insurer is not responsible for claimant's CTS. If claimant's self-employment was not subject to ORS Chapter 656, he is not entitled to workers' compensation benefits. *See Likos* at 490 ("Claimant is not entitled to receive compensation, however, because [claimant's self-employment], the last potentially causal employment before claimant sought medical treatment and at which claimant's claim accrued, was not subject to Workers' Compensation Law.").

ORDER

The ALJ's order dated June 17, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[5] If the claimant 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, *rev den* 319 Or 81 (1994). Liability for the claim can be transferred 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. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Reynolds Metals*, 157 Or App at 153.

In the Matter of the Compensation of
ERNEST W. MERCER, Claimant
Own Motion No. 96-0253M
OWN MOTION ORDER OF ABATEMENT
Cummins, Goodman, et al, Defense Attorneys

The insurer requests reconsideration of our December 16, 1998 Own Motion Order, in which we set aside the insurer's June 15, 1998 Notice of Closure as premature and remanded the claim to the insurer for further processing in accordance with law. The insurer further requests that because of the complexity and voluminous nature of this claim, a briefing schedule be established.

In light of such circumstances, the following briefing schedule shall be implemented. The insurer shall have 21 days from the date of this order to file its opening brief. Claimant shall have 21 days from the date of mailing of the insurer's brief to file his response. The insurer shall then have 14 days from the date of mailing of claimant's response to file its reply. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARENCE A. MOORE, Claimant
WCB Case Nos. 98-00560 & 97-06763
ORDER ON REVIEW
Scott McNutt Sr., Claimant Attorney
James B. Northrop (Saif), Defense Attorney
William J. Blitz, Defense Attorney

Reviewed by Board Members Moller and Biehl.

Barrett Business Services requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its compensability and responsibility denials of claimant's right knee medial meniscus tear; and (2) upheld the SAIF Corporation's denials, on behalf of Cardinal Services, of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change the first sentence of the findings of fact to read: "Claimant has worked at a shopping mall as a custodian since July 1996 and has been a supervisor since August 1996. (Tr. 6, 7, 18)." We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked at a shopping mall as a custodian since July 1996 and has been a supervisor since August 1996. (Tr. 6, 7, 18). He was hired initially by Campbell Janitorial Services, which in turn contracted with Barrett Business Services (Barrett) for actual performance of the labor. That situation continued until April 27, 1997, when there was a brief break in workers' compensation coverage. On May 12, 1997, claimant became an employee of Cardinal Services (Cardinal), performing the same work at the same location. (Tr. 4).

The issues in this case are compensability and responsibility of claimant's right knee medial meniscus tear. The ALJ found that the onset of claimant's disability was in March 1997 and he assigned initial responsibility for claimant's right knee condition to Barrett. The ALJ concluded that there was no actual contribution to the worsening of claimant's disability during his employment with Cardinal and, therefore, responsibility for the condition remained with Barrett. Although we agree with the ALJ's conclusion, we provide the following analysis.

On review, Barrett contends that there are "suspicious circumstances" of the historical presentation by claimant. Barrett argues that claimant suffers from two separate right knee conditions, with two separate periods of treatment, *i.e.*, condylitis and a right medial meniscus tear. Barrett contends that the ALJ applied an incorrect standard to determine responsibility for claimant's right medial meniscus tear.

We first address Barrett's argument concerning claimant's credibility. 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 conclude that claimant is a credible witness. He testified that on February 14, 1997, at approximately 8:15 a.m., he injured his right knee while removing scuff marks from the floor at work. (Tr. 25-26, Ex. 4). He put his right shoe over the scuff mark, placed his weight on the right foot, and twisted the foot back and forth to remove the scuff mark. (Tr. 7-8). While twisting his foot, claimant felt a sudden pain in the right inner knee. (Tr. 7-8, 26). Claimant's right knee symptoms did not change after the February 14, 1997 injury. (Tr. 10, 14, 29).

The medical report from Dr. Laudenschlager is consistent with claimant's testimony. Claimant sought treatment from him on July 1, 1997 when his knee symptoms did not improve. (Tr. 14). Dr. Laudenschlager reported that claimant had developed right knee pain in February after spending several days working at the mall removing scuff marks from the flooring. (Ex. 3-1). Claimant's "801" form signed on July 2, 1997, and the "827" form both referred to twisting his leg while removing scuff marks. (Ex. 4, 5).

Claimant's first treatment for the right knee condition was on March 13, 1997, when he was examined by Dr. Gabert in the emergency room. Dr. Gabert reported that claimant had an "approximately two month history of pain in the medial portion of his right knee[.]" (Ex. 1). Claimant denied any history of trauma. (*Id.*) Dr. Gabert diagnosed "[r]ight knee pain, uncertain etiology, probably condylitis." (*Id.*) Claimant did not recall telling Dr. Gabert that there was no trauma. (Tr. 13). He paid for the emergency room visit himself because he did not want to file a claim. (Tr. 13, 39). He was concerned about losing his job. (Tr. 39).

On July 17, 1997, claimant was treated by Dr. Freudenberg, who reported a history of medial right knee pain since February 1997. (Ex. 6). Dr. Freudenberg indicated claimant could not recall a specific injury, but he did quite a bit of twisting, squatting and kneeling at work. (*Id.*)

Although the medical reports from Drs. Gabert and Freudenberg did not refer specifically to claimant's "scuff mark" incident in February 1997, we are persuaded by claimant's testimony, as well as Dr. Laudenschlager's report, that claimant injured his right knee in February 1997 after removing scuff marks at work. We note that Mr. Campbell, claimant's supervisor, testified that claimant was a "very good" employee and he had no reason to doubt his credibility. (Tr. 43, 44, 46).

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard v. Renalds*, 132 Or App 288 (1995)). According to Barrett, claimant's medial meniscus tear should be analyzed as an occupational disease. Barrett asserts that claimant's condition was first treated in July 1997 and, therefore, Cardinal is responsible for the right medial meniscus tear. On the other hand, claimant and SAIF contend that the right medial meniscus tear should be analyzed as an injury.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's right knee condition occurred as an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. *Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984).

As we have discussed, claimant testified that he felt a sudden pain in his right inner knee on February 14, 1997, while he was removing scuff marks from the floor. (Tr. 7-8, 25-26, Ex. 4). Claimant's right knee symptoms continued to be the same after the February 14, 1997 incident. (Tr. 10, 14, 29). Thus, claimant's symptoms began after the February 14, 1997 work incident and continued thereafter. Because claimant's symptoms were sudden in onset and occurred over a discrete, identifiable period of time, we conclude that the claim should be analyzed as one for an accidental injury.

Claimant argues that the material contributing cause standard applies to this case. We need not resolve this particular issue, however, because we conclude that Dr. Freudenberg's opinion is sufficient to sustain claimant's burden of proof under either the material or major contributing cause standard.

For the following reasons, we are not persuaded by Barrett's argument that claimant suffers from two separate right knee conditions, with two separate periods of treatment, *i.e.*, condylitis and a right medial meniscus tear. Rather, we find that the original diagnosis of condylitis was only a preliminary diagnosis and further testing made it clear that claimant had a medial meniscus tear. On March 13, 1997, Dr. Gabert diagnosed "[r]ight knee pain, uncertain etiology, probably condylitis." (Ex. 1). Dr. Gabert referred claimant to Dr. Laudenschlager. (*Id.*) Claimant sought treatment from Dr. Laudenschlager on July 1, 1997, because of continued knee symptoms. (Ex. 3-1). Claimant was then referred to Dr. Freudenberg, who diagnosed a right medial meniscus tear, which was confirmed by an MRI. (Exs. 6, 8).

Dr. Gabert is an emergency room physician and we find that her diagnosis of "probably condylitis" was only a preliminary diagnosis. Claimant testified that his right knee symptoms did not change after the February 1997 incident. (Tr. 10, 14, 29). When claimant was eventually referred to an orthopedic surgeon, Dr. Freudenberg diagnosed a right medial meniscus tear. In light of claimant's continued and unchanged right knee symptoms, we are not persuaded by Barrett's argument that claimant had two separate and distinct conditions.

Barrett argues that Cardinal is responsible for claimant's condition and it relies on Dr. Freudenberg's comments that indicated claimant's general employment activities were the major contributing cause of the medial meniscus tear. On the other hand, when Dr. Freudenberg was provided with a more complete history that claimant's right knee pain began in February 1997 while removing scuff marks, he concluded that claimant tore his meniscus at that time. (Exs. 18-2, 19-24, -25). In a concurrence letter from SAIF, Dr. Freudenberg agreed that it was medically probable claimant sustained a medial meniscus tear when he was removing scuff marks from the floor with his foot. (Ex. 18-2). In a deposition, he adhered to that opinion. (Ex. 19-23, -24). Dr. Freudenberg testified that the scuff mark activity was the "most significant incident" and he agreed that the real tearing of the meniscus occurred at the specific moment when claimant felt right knee pain. (Ex. 19-19, -25). Dr. Freudenberg agreed that claimant's initial tear was more significant in determining major contributing cause than his later work activities. (Ex. 19-26). Although claimant's weight was a factor, Dr. Freudenberg explained that claimant's work played a more important role than his weight. (Ex. 19-11).

Although Dr. Freudenberg's later medical opinion differed from his earlier reports on causation referring to claimant's work activities in general, we find his change of opinion to be reasonable in light of the fact that he was subsequently informed of claimant's history of right knee pain in February 1997 after removing scuff marks at work. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive). Moreover, we are persuaded by Dr. Freudenberg's opinion because it is well-reasoned and based on an accurate and complete history. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Based on Dr. Freudenberg's opinion, we conclude that the February 14, 1997 "scuff mark" incident was the major contributing cause of claimant's disability or need for treatment of the right medial meniscus tear. Therefore, claimant has established compensability.

The remaining question is which carrier is responsible for claimant's right medial meniscus tear. Once it is established that a condition is work related, the last injurious exposure rule assigns responsibility to the last period of employment whose conditions might have caused the disability. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). If a claimant receives medical treatment for a compensable condition before experiencing time loss due to the condition, then the date of first medical treatment is determinative for assigning initial responsibility for the claim. *Reynolds Metal v. Rogers*, 157 Or App 147, 153 (1998); *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. *SAIF v. Kelly*, 130 Or App 185, 188 (1994).

Here, claimant first received medical treatment for his right knee condition on March 13, 1997. (Ex. 1). His right knee condition was later diagnosed as a right medial meniscus tear. In March 1997, Barrett was on the risk and is assigned initial responsibility for claimant's meniscus tear.

Although claimant did not rely on the last injurious exposure rule of proof to establish compensability, Barrett can rely on the last injurious exposure rule of responsibility as a defense. *See Willamette Industries, Inc. v. Titus*, 151 Or App 76, 81 (1997) (employers may assert the last injurious exposure rule of responsibility as a defense even when a claimant has chosen to prove actual causation). A necessary factual predicate for the defensive use of the rule of responsibility is proof that "the subsequent employment actually contributed to the worsening of an underlying disease." *Id.*, quoting *Spurlock v. International Paper Co.*, 89 Or App 461, 465 (1988). Proof that the subsequent employment (Cardinal) independently contributed to the current disability is required before the rule of responsibility can be invoked defensively by the targeted employer, *i.e.*, Barrett. *See id.*, 151 Or App at 82.

In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." *Bracke v. Baza'r*, 293 Or 239, 250 (1982); *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992) (later employment conditions actually contribute to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. *Timm v. Maley*, 134 Or App 245, 249 (1995); *see Bracke*, 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

Claimant became an employee of Cardinal on May 12, 1997. (Tr. 4). We find that the medical evidence does not establish that claimant's subsequent employment with Cardinal actually contributed to the worsening of his right medial meniscus tear. Claimant testified that his right knee symptoms did not change after the February 14, 1997 "scuff mark" incident. (Tr. 10, 14, 29). He explained that basically any movement bothered his knee. (Tr. 14). In a concurrence letter with SAIF, Dr. Freudenberg agreed that "continued activity, once a meniscus is torn, can worsen the condition." (Ex. 18-2). Nevertheless, Dr. Freudenberg agreed that in determining major causation, the contribution from claimant's later activities was not as significant as the initial tear. (*Id.*) Dr. Freudenberg adhered to that opinion in a deposition. (Ex. 19-26). He agreed that a meniscal tear was the type of medical condition that could continue to progress with continued activity. (Ex. 19-8, -9, -17). In claimant's case, however, Dr. Freudenberg said he had not examined claimant since August 1997 and could not say whether the meniscal tear had progressed or deteriorated. (Ex. 19-9).

Dr. Freudenberg's comments that continued work activities can worsen a medial meniscus tear establishes, at most, the possibility that claimant's later work activities at Cardinal actually contributed to the worsening of the tear. *See Gormley v. SAIF,* 52 Or App 1055 (1981) (medical opinion must be stated in terms of reasonable medical probability, not mere possibility). We find that the medical evidence is insufficient to establish that claimant's employment activities with Cardinal actually contributed to the worsening of his right medial meniscus tear. Consequently, Barrett has not established the necessary factual predicate for the defensive use of the rule of responsibility. *See Titus,* 151 Or App at 81. Because the medical evidence does not establish that claimant's subsequent employment at Cardinal independently contributed to his right medial meniscal tear, we conclude that responsibility for claimant's right knee condition remains with Barrett.

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 Barrett Business Services. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 10, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by Barrett Business Services.

January 13, 1999 Cite as 51 Van Natta 39 (1999)

In the Matter of the Compensation of
DYONA J. POTTER, Claimant
Own Motion No. 97-0556M
OWN MOTION ORDER
Cathcart & Borden, Claimant Attorneys
Travelers Indemnity, Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for claimant's compensable left L5-S1 disc herniation. Claimant's aggravation rights expired on July 21, 1994. The insurer opposed reopening the claim on the grounds that surgery or hospitalization is not reasonable and necessary for the compensable injury.

Claimant appealed the medical services issue to the Medical Review Unit (MRU) of the Workers' Compensation Division, as jurisdiction over medical service disputes resides with the director. ORS 656.245(6), 656.260, 656.327 and 656.704(3). On March 26, 1998, the Board issued its order postponing action on the own motion matters pending outcome of the medical services dispute.

On October 30, 1998, the MRU issued an Administrative Order (Order No. TX 98-659), which found that the proposed left L5-S1 microdecompression and microdiscectomy was appropriate medical treatment for claimant's compensable injury. That order became final on November 30, 1998.

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

Here, the dispute regarding the reasonableness and necessity of claimant's surgery has been resolved. ORS 656.327. Because it has been determined that the insurer is responsible for claimant's proposed medical treatment, we find that claimant is entitled to temporary disability compensation for surgery which has been determined to be reasonable and necessary for claimant's compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, 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
WAYNE L. REED, Claimant
WCB Case No. 97-09379
CORRECTED ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

It has come to our attention that our December 31, 1998 Order on Review contains a clerical error. Specifically, the "Order" portion of our decision provides that claimant, rather than "claimant's attorney" is awarded the $3,200 attorney fee for the hearing level.

To correct this error, we withdraw our December 31, 1998 order. In its place, we republish our December 31, 1998 order, replacing the "Order" portion of our prior order with the following paragraph:

"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's attorney 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."

The parties' rights of appeal shall begin to run from the date of this order.

In the Matter of the Compensation of
JACK B. ROY, Claimant
WCB Case No. 97-00659
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Bock and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of claimant's left medial meniscus tear and current left knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings," which we summarize and supplement below.

Claimant sustained a Grade III tear of the posterior horn of his left medial meniscus as the result of a compensable work injury on August 14, 1996. Treatment for this injury included surgical removal of the torn meniscus area on October 1, 1996, and post-surgery physical therapy. On October 25, 1996, claimant reinjured his left knee when he slipped and fell in a parking lot enroute from a physical therapy session.

Prior to the reinjury, claimant was demonstrating marked, progressive improvement and was released to light work. Following the reinjury, claimant experienced continued popping in the knee and a significant increase in left knee pain. Dr. Witczak took claimant off work and provided further conservative care. When claimant's condition had not improved by mid-December 1996, Dr. Witczak ordered an MRI that demonstrated a new Grade III tear of the posterior horn of the left medial meniscus.

On January 9, 1997, SAIF issued a denial of the new meniscus tear as a noncompensable "consequential condition," and a denial of claimant's "current condition" on the ground that the noncompensable consequential condition was the major cause of claimant's current disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's new meniscus tear and current condition were not compensable under ORS 656.005(7)(a)(A). Pursuant to that provision, "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." We affirm the ALJ's decision based on the following supplemental rationale.

On review, claimant contends that the ALJ erred in analyzing this claim as a "consequential condition." In support of that argument, claimant reasons that the record does not establish a new meniscus tear, as distinct from a mere symptomatic exacerbation of the accepted meniscus tear. Claimant further reasons that ORS 656.005(7)(a)(A) is not applicable because claimant's accepted injury directly and materially contributed to claimant's reinjury and current need for treatment and disability.

Resolution of the diagnostic and compensability issues in this case involves complex medical questions that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Special deference is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no persuasive reason not to defer to the unrebutted opinion of Dr. Witczak, the treating surgeon. Dr. Witczak opined that claimant sustained a new tear of the left medial meniscus when he fell in the parking lot on October 25, 1996. Dr. Witczak further opined that, while the residuals of claimant's compensable surgery contributed to the new tear and the subsequent disability and need for treatment, the fall in the parking lot was the major contributing cause.

In light of Dr. Witczak's unrebutted opinion, we find that claimant's reinjury resulted in a new meniscus tear that is a "consequential condition" within the meaning of ORS 656.005(7)(a)(A), and that the accepted injury was not the major contributing cause of the new meniscus tear or claimant's subsequent disability and need for treatment. *See Richard Perle*, 50 Van Natta 2195 (1998). Accordingly, we conclude that claimant has not established a compensable claim for the new meniscal tear or his current condition.[1]

In reaching this decision, we rely on our finding that the meniscus tear demonstrated on the December 20, 1996 MRI is different from the accepted condition. Because the accepted meniscus tear was surgically excised rather than repaired, the reinjury resulted in a new tear rather than a recurrence or worsening of the accepted tear.[2] In addition, we find that the record does not establish a *direct* relationship between the new meniscus tear and the accepted injurious event on August 14, 1996. Rather, Dr. Witczak's unrebutted opinion establishes that the new meniscus tear was *indirectly* related to the compensable event because it was caused, in part, by surgery performed for the compensable condition.[3]

Furthermore, we are persuaded that claimant's new meniscus tear falls within the definition of a "consequential condition" discussed in *Hicks v. Spectra Physics*, 117 Or App 293 (1992). The *Hicks* court concluded that an injury sustained in an automobile accident enroute from treatment for a compensable condition was a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). The court reasoned that the legislature intended to restrict the compensability of "injuries that are the result of activities that would not have been undertaken but for the compensable injury." *Id.* In so doing, the court relied on excerpts of the legislative debate expressing a clear desire to nullify the holding in *Fenton v. SAIF* that an injury sustained in an accident occurring enroute to treatment for a compensable injury is compensable. 87 Or App 78, *rev den* 304 Or 311 (1987).[4]

We acknowledge that the present case is distinguishable from *Hicks* because, here, the new condition involves the same body part as the accepted condition, and the residuals of the accepted injury materially contributed to the new meniscus tear. Nevertheless, the underlying rationale in *Hicks* is equally applicable here, *i.e.*, claimant's new meniscus tear occurred enroute from treatment and is, thus, the result of an activity that would not have been undertaken but for the compensable injury.[5]

Consistent with the above rationale, we affirm the ALJ's conclusion that claimant's new meniscus tear is a noncompensable consequential condition under ORS 656.005(7)(a)(A). It, therefore, follows that claimant's "current condition" is not compensable so long as the new meniscus tear remained the major contributing cause of claimant's disability and need for treatment. To conclude otherwise would circumvent the legislature's intent in enacting ORS 656.005(7)(a)(A).

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[1] As the evidence is not in equipoise, we need not address claimant's argument that SAIF has the burden of proving that claimant's current condition should be analyzed under ORS 656.005(7)(a)(A).

[2] *See Beck v. James River Corp.*, 124 Or App 484 (1993) (ORS 656.005(7)(a)(A) applies to claims for new injuries or conditions different from an already accepted claim and, therefore, is not applicable where a noncompensable EMG results in a need for further treatment of an accepted shoulder condition; treatment is compensable under ORS 656.245 because it is materially related to the accepted injury). *See also Roseburg Forest Products v. Ferguson*, 117 Or App 601, *rev den* 316 Or 528 (1993) (ORS 656.005(7)(a)(A) is not applicable to emergency room treatment to repair broken sutures at the site of a compensable carpal tunnel surgery; treatment is compensable as continued medical services under ORS 656.245 because it is materially related to the compensable carpal tunnel condition).

[3] *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (condition or need for treatment that is *directly* caused by an industrial accident is analyzed under a material contributing cause standard; condition or need for treatment that is caused in turn by a compensable condition is analyzed under the major contributing cause standard as a consequential condition).

[4] *Compare Barrett Business Services v. Hames*, 130 Or App 190 (1994) (where the claimant suffered a new injury *during* reasonable and necessary treatment of a compensable condition, the compensable injury was the major contributing cause of the consequential condition).

[5] *See also Ruben Juarez*, 48 Van Natta 447 (1996) (claim was properly analyzed as a consequential condition because it resulted from the combined effect of an accepted low back condition, subsequent degenerative changes in the lumbar spine, and claimant's current activities).

Finally, we note that our decision does not effect SAIF's continued responsibility for any future treatment and disability that is compensably related to the accepted August 14, 1996 injury.

ORDER

The ALJ's order dated April 16, 1998, as reconsidered on June 3, 1998, is affirmed.

January 13, 1999 Cite as 51 Van Natta 43 (1999)

In the Matter of the Compensation of
SUSAN M. SHOTTHAFER, Claimant
WCB Case No. 98-01697
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's mental disorder claim for depression; and (2) awarded an assessed attorney of $8,000. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

In September 1996, claimant began working as a high school teacher. She taught Spanish and film literature. Claimant's position was probationary for the first three years, which meant that claimant was subject to a more rigorous evaluation process and her contract could be terminated more easily than a permanent teacher.

Claimant taught in a "portable" that was not part of the main school building. Claimant testified that Darold Powell, the principal, told her to impose discipline because the students had considered the "portable" as a place to "party." According to claimant, when she was introduced at a school assembly, some students "booed" her. Claimant attributed this to her attempt to follow Principal Powell's direction to impose a disciplinary approach.

Claimant also testified that, during her first week of teaching, the portable was "egged." Claimant also found that the air from her tires had been let out.

In January 1997, after claimant taught for one semester, Principal Powell wrote to claimant noting that her "D1 class started the year at 22 and is now 11 and that D2 class started at 20 and is now 13." (Ex. 5). The letter asked claimant to give "serious thought" in making the "classes more attractive to students," adding that, "if we lose the students we lose the classes and the program and therefore the position." (*Id.*) The letter encouraged claimant "to consider grades and praise more in line with what [the students] are used to receiving." (*Id.*)

In March 1997, claimant received her first evaluation. It noted that claimant was "somewhat of a perfectionist" and that the "high school scene has been difficult for [claimant]." (Ex. 11-1). The evaluation also stated that "Spanish is an elective program which [sic] [claimant] needs to build." (*Id.*) Nevertheless, Principal Powell recommended continuation of claimant's employment. (*Id.*) Shortly thereafter, Dr. Paul Prevenas, Superintendent of the Board of Education, notified claimant of the Board's intent to renew her probationary teacher contract for the 1997-98 school year. (Ex. 12). Claimant accepted the contract renewal. (*Id.*)

In June 1997, claimant gave a final exam in her Spanish class. Grades for the exam were: one student received a "B", three students received a "C", four received a "D", and eleven received an "F". (Ex. 14-5). Shortly after claimant graded the exams, the mother of a student confronted claimant at school concerning her daughter's exam. Because other students were taking a test, claimant asked the woman to return at a more convenient time.

When the mother returned the next day, claimant told her that her daughter's grade was "D" on the final exam. (*Id.* at 3). Apparently, the mother was very angry with claimant and wrote a letter to the principal complaining about claimant.[1] Another mother of a student who failed the exam also apparently met with claimant and expressed her anger about the grade. (*Id.* at 5). In response, claimant wrote a lengthy letter to Principal Powell explaining her meetings with the parents and her grading system. Claimant also raised four students' final grades to "A" (two of these students were children of the angry parents), three students' final grades to "C", and two students' final grades to "D".

In July, Principal Powell wrote to claimant telling her he had received her letter and that he also had received a letter, as well as telephone calls and "personal visits," from other parents complaining about the Spanish class. Principal Powell expressed concern "about the amount and degree of strong feeling about your teaching ability * * * especially in that most concerns come from some of our strongest students and very involved parents. I feel it will be very difficult for you to overcome the reputation you have established in the student body and the community." (Ex. 15). The letter further stated that he would recommend to Superintendent Prevenas that the Board withhold a salary step increment and that he would meet with claimant to establish a "plan of assistance." (*Id.*)

Superintendent Prevenas then sent claimant a letter informing her of Principal Powell's formal recommendation to withhold a salary step increment and providing her an opportunity to respond. (Ex. 16).

The following day, claimant sought treatment for gastritis and anxiety.

Claimant's response to Superintendent's Prevenas' letter stated that she had been informed by her attorney that Principal's Powell's recommendation was in violation of her contract. The letter also defended her grading of the final exam and objected to a deadline imposed by Principal Powell concerning submission of transcripts for claimant's correspondence courses. (Ex. 23).

On August 8, 1997, claimant's husband called the county sheriff about the presence of suspicious teenagers by his house. (Ex. 20). According to claimant, her husband saw two teenagers stop by her house and point to it. Her neighbor then told her that, after dark, a group of teenagers came to the house carrying something in their hands. Claimant's house was not "egged" or shot with paint balls.

Another parent of a Spanish class student wrote Principal Powell a letter complaining about her daughter's final grade of "D" as well as an incident when claimant took the parent aside to express her concern about her daughter's performance in class while the mother and her daughter were crying over a family situation. (Ex. 24). The parent asked Principal Powell to raise the grade and "consider removing [claimant] from our school district." (*Id.*)

In response, claimant wrote to Principal Powell stating that the parent had "no factual support for her accusations." (Ex. 21-1). She further stated that she would not have approached the parent about her daughter's declining grade if she had known they were in a "crisis." (*Id.*) Finally, claimant refused to raise the grade. (*Id.* at 2). Meanwhile, claimant continued to be treated for depression and anxiety. (Ex. 22).

On August 27, 1997, Superintendent Prevenas wrote to claimant stating that, although her formal written performance evaluation was not "substandard," "several alleged actions" after the evaluation "raise legitimate questions as to the actual quality of your overall performance for the 1996-97 school year." (Ex. 25-1). The letter further explained that, because the evaluation was not "substandard," the school district could not withhold the salary increment. (*Id.*) Instead, Superintendent Prevenas directed Principal Powell to "commence the evaluation process * * * immediately upon the start of the upcoming 1997-98 school year" and, pending the results of the evaluation, Prevenas "reserved" the option to withhold a salary increment for the remaining portion of the school year. (*Id.*) Finally, Prevenas refused to omit documents from claimant's personnel file. (*Id.* at 2).

On September 10, 1997, after the school year began, claimant submitted performance goals to Principal Powell for her Spanish I class. (Ex. 30). For one of her classes, claimant did not have enough textbooks for her students because the textbooks had not been timely ordered (ordering the textbooks was not claimant's responsibility). Due to the shortage, claimant photocopied portions of the textbook until the textbooks arrived about a month after the start of school.

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[1] Although the record contains references to this letter, it is not in the record.

About the same time, a parent of one of claimant's Spanish students wrote to Principal Powell expressing concern about the textbook shortage and potential copyright infringement problems from copying portions for distribution. (Ex. 32). The parent also noted that she had observed the class and that, "[a]ll things considered, I think this specific Spanish I class has been a bad situation." (*Id.*) Principal Powell provided a copy of the letter to claimant, accompanying it with a memorandum stating that he considered the parent's "complaint serious and we will need to meet with her to discuss these concerns." (Ex. 35). Principal Powell later informed claimant that she did not need to meet with the parent but gave her the opportunity to meet with him "to discuss the issues" raised by the parent. (Ex. 37).

On October 2, 1997, Principal Powell sent a memorandum to claimant stating that two other parents of Spanish students had met with him with concerns about the class. (Ex. 40).

On October 3, 1997, Principal Powell informed claimant that he "had three phone calls and one parent stop by to tell me that there are probably 12 to 15 of your students' parents calling each other unhappy about your class" and that "they plan to come in a group to confront you and observe your class." (Ex. 41). The memorandum further stated that he had "told these [sic] who contacted me that I do not want that to happen, that they should meet with me and/or you in the office area" and claimant should tell them to go to the office if they came to the class. (*Id.*)

On October 16, 1997, Principal Powell wrote to claimant that several Spanish students had complained to him about the class and attached another memorandum outlining the complaints. (Ex. 44). Principal Powell also told claimant that he and the Assistant Principal would be formally and informally observing her class and that he wanted claimant "to have your classes in good control and present a good atmosphere for learning Spanish." (*Id.*)

On October 24, 1997, Principal Powell performed a formal observation. (Exs. 46, 47). Claimant responded that Powell's "illogical comments in your letters and several comments in your evaluation of me are a loathsome annoyance" and that his "consistent inability to face reality and your persistent use of me as a scapegoat for the irresponsible behavior of some students and some parents is inexcusable." (Ex. 49).

On October 27, 1997, Principal Powell wrote to claimant that, because they had not met to discuss the students' complaints, he had "not heard your side" and that he believed "there is a high level of frustration and resentment which may be interfering with your ability to teach." (Ex. 50). Claimant's response was that the "complaints/accusations the students have made against me are false and have no support" and that "some of these statements are incomplete, incoherent, and/or do not make sense." (Ex. 51).

On November 4, 1997, claimant began counseling with Kathleen Kosche, psychologist. (Ex. 53).

On November 5, 1997, claimant received a Notification of Performance Deficiency. (Ex. 54).

On November 12, 1997, claimant began treating with psychiatrist, Dr. Martin. (Ex. 56).

On November 17, 1997, claimant sent Principal Powell a memorandum discussing a conference with a parent, quarter grading, and performance problems with some of her students. (Ex. 59).

On November 14 and 18, 1997, the Assistant Principal informally observed the Spanish class. (Ex. 60).

On November 26, 1997, claimant's treating osteopath, Dr. Manuele, removed claimant from her job in order to treat her physical and mental health. (Ex. 61). On the same day, claimant filed a workers' compensation claim. (Ex. 63).

On December 2, 1997, Principal Powell completed claimant's performance evaluation, recommending a plan of assistance. The next day, the Assistant Principal completed another Notice of Performance Deficiency. (Ex. 66).

On December 4, 1997, Principal Powell wrote to claimant, explaining that, because a sufficient number of observations were conducted before she left, it was appropriate for him to complete a formal evaluation. (Ex. 67-1). The letter included a copy of the evaluation and invited claimant to meet with him to review the evaluation. (*Id.*)

On December 11, 1997, Principal Powell completed a Plan of Assistance, describing claimant's "deficiency" as "a lack of rapport with students" and "poor classroom management skills." (Ex. 68-2). The plan was sent to claimant.

On February 11, 1998, Superintendent Prevenas informed claimant that he was considering a recommendation not to renew her contract for the following school year and provided her an opportunity to meet with him to discuss the recommendation. (Ex. 75). On February 26, 1998, Superintendent Prevenas notified claimant of the Board's decision not to renew her contract. (Ex. 83).

On February 24, 1998, claimant reported to the sheriff that two car tires had been slashed. (Ex. 77).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had proved all the factors necessary for a compensable mental stress claim and, therefore, she carried her burden of proof. *See* ORS 656.802(3). The insurer contends that, because the major contributing cause of claimant's mental condition is "reasonable disciplinary, corrective or job performance evaluation actions by the employer" or "conditions generally inherent in every working situation," claimant did not prove compensability.

In determining compensability, the ALJ relied on a lengthy list compiled by claimant of "all factors that caused" claimant's stress. (Ex. 89-10). Those factors included threats by students to "egg" her house, "booing" when claimant was first introduced at the assembly, "egging" of the "portable" the first week of school, and having the air let out of her car tires. (*Id.*) The list also refers to Principal Powell's January 1997 letter concerning dropping enrollment in her Spanish class; a parent's "false statements"; the angry confrontations with two parents in June 1997; the July 1997 letter from Principal Powell concerning his recommendation to withhold the salary step increment; the July 1997 letter from another angry parent; Superintendent Prevenas' July 1997 letter; the September 1997 letter from a parent; the September 1997 letter from Principal Powell warning claimant about a group of parents planning to confront claimant; and the correspondence sent to claimant after she went on medical leave (which included the evaluation and Notice of Performance Deficiency). (*Id.* at 11, 13, 15, 19-21, 24, 26).

When seeking treatment with Ms. Kosche, claimant identified stressful factors as the July 1997 "Course of Correction" notice[2]; criticism from administration and parents concerning her grading system and lack of classroom control; and "lies and distortions of situations as they occurred in her classroom or with her work." (Ex. 53-1, -2). At hearing, Dr. Martin testified that claimant experienced "pressure" from students and parents concerning grades and that claimant was stressed over "threats" by her supervisor of "being placed on some kind of special supervision or terminated from her job[.]" (Tr. 6). Dr. Martin also discussed the threat of a group of parents confronting her in her classroom and the slashing of her car tires. (*Id.* at 13).

Based on such evidence, we find that one of the principal causes of claimant's mental condition was the criticism from her students and their parents, including the confrontations with two parents in June 1997, the numerous letters sent by parents to Principal Powell, the information from Principal Powell of oral criticism, and Principal Powell's warning that a group of parents intended to confront claimant in her class.

In showing a compensable mental disorder, claimant must prove that the employment conditions causing the condition were other than those "generally inherent in every working situation." *See* ORS 656.802(3)(b). Conditions "generally inherent in every working situation" are those common to all employment, not merely the specific occupation involved. *Housing Authority of Portland v. Zimmerly*, 108 Or App 596, 599 (1991). We are authorized to determine what conditions are common to all employment on a case-by-case basis. *SAIF v. Campbell*, 113 Or App 93, 96 (1992).

As claimant herself testified, "doctors, lawyers, clerks, carpenters -- I think just about every field -- you're liable to have someone who complains about your work. I don't think you can satisfy everyone." (Tr. 59). The extent of criticism experienced by claimant, however, is not "generally inherent." Claimant was confronted in her classroom by angry parents, received copies of letters from

[2] We interpret this as referring to the correspondence from Principal Powell and Superintendent Prevenas concerning the recommendation to withhold the salary step increase.

parents criticizing her grading system and demanding her termination, and was informed about Principal Powell's meetings with numerous parents and students and their complaints about claimant's teaching, as well as warned about a group of parents who intended to confront claimant in her class. Moreover, claimant was openly criticized at school by students when she was "booed" at the assembly, her "portable" was "egged," her car tires slashed, and her husband saw teenagers in front of her house. Claimant also was blamed for some matters for which she was not responsible, like the delayed delivery of textbooks, and possible copyright infringement.

In short, we find that such incidents show that claimant's work was not just criticized--she was threatened and intimidated. We conclude that such circumstances are not "generally inherent."

We further find that another primary factor in causing claimant's mental condition was the actions by Principal Powell and the Assistant Principal in response to complaints and criticism from parents and students, including Powell's January 1997 letter concerning dropping enrollment, his recommendation to withhold a salary step increase and Superintendent Prevenas' correspondence concerning the recommendation.

Employment conditions that constitute "reasonable disciplinary, corrective or job performance evaluation actions by the employer" are not considered in determining compensability of a mental disorder. *See* ORS 656.802(3)(b).

We first address the January 1997 letter from Principal Powell to claimant expressing concern about dropping enrollment in claimant's Spanish classes and suggesting that claimant consider giving grades and praise "more in line" with what the students were accustomed to receiving. Because the letter did provide only a suggestion and did not direct claimant to teach in a different manner, we do not consider the letter as "disciplinary, corrective or job performance evaluation" action. Consequently, whether reasonable or not, we consider it in deciding the compensability of claimant's mental disorder.

But Principal Powell's recommendation to withhold claimant's salary increment increase was a disciplinary action. The record, however, contains no evidence explaining the proper procedure, if any, for making such a decision. The fact that Superintendent Prevenas decided not to approve the recommendation because claimant's evaluation had not been "substandard" suggests that Principal Powell's action was premature. For this reason, we find that the recommendation was unreasonable.

Thus, we conclude that we properly consider whether parent and student criticism and the actions taken by school administrators were the major contributing cause of claimant's mental condition. Because the medical opinions uniformly show that such employment were the major contributing cause, we agree with the ALJ that claimant proved this element of compensability.

Finally, there is no dispute that the employment conditions exist in a real and objective sense; the mental disorder is a generally recognized in the medical or psychological community; and the mental disorder arose out of and in the course of employment. Consequently, claimant proved compensability of the mental disorder. *See* ORS 656.802(3).

Attorney Fees

The insurer also disputes the ALJ's attorney fee award of $8,000, asserting that a more appropriate fee is $3,500 for services at hearing. We consider the factors set forth in OAR 438-015-0010(4) in deciding a reasonable attorney fee. These factors are:

"(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."

According to claimant's counsel, he devoted 40 hours at the hearings level. The hearing lasted three and a-half hours; three witnesses testified. The record consisted of approximately 90 exhibits. The issue at hearing was the compensability of claimant's mental disorder claim.

Based on such evidence, we find that the time devoted to the case was greater, and the nature of the proceeding was more complex, than the average case litigated before the Hearings Division. Similarly, given the many elements of a mental disorder claim, we find the issue to more complex than average.

Claimant's attorney secured valuable benefits for claimant and, in light of the competing factual and medical evidence, there was a substantial risk that claimant's attorney might go uncompensated. Finally, there is no assertion of frivolous issues or defense.

In light of these factors, especially the time devoted to the case, the complexity of compensability issue, and the substantial risk that claimant's counsel might go uncompensated, we find the assessed attorney fee of $8,000 to be reasonable.

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

Board Member Moller dissenting.

I disagree with the majority that claimant proved compensability of her mental stress claim. Thus, for the following reasons, I dissent.

First, like the ALJ, the majority relies on the lengthy list compiled by claimant of "all factors that caused" her stress. (Ex. 89-10). The problem with this approach is that the medical providers do not also identify each of these factors as contributing to claimant's psychological condition. For instance, there is no mention by Ms. Kosche or Dr. Martin concerning students "booing" claimant at an assembly, the "egging" of the "portable" or the delayed delivery of textbooks. Because there must be *expert* medical evidence that employment conditions were the major contributing cause of claimant's mental condition, I would not include any factor that is not identified by Ms. Kosche, Dr. Martin or examining psychiatrist Dr. Fried. For this reason, I consider claimant's list to be of limited relevance in determining compensability.

Based on the medical evidence, I also agree with the majority that another primary factor in causing claimant's mental condition was the actions by Principal Powell and the Assistant Principal in response to complaints by students and parents. Specifically, both Ms. Kosche and Dr. Martin identify Principal Powell's recommendation to withhold a salary step increase and Superintendent Prevenas' correspondence concerning the recommendation and his eventual decision to begin the evaluation process at the start of the 1997-98 school year. Because the majority limits its discussion to the January 1997 letter from Principal Powell and his recommendation to withhold claimant's salary increment increase, I believe the majority does not fully consider these factors.

As a probationary teacher, claimant had to be evaluated at least once during the school year. (Ex. 88-3). All evaluations had to be preceded by at least two formal or informal observations. (*Id.*). A preevaluation interview also had to be scheduled at least once each year and could include the establishment of individual performance goals. (*Id.*). Established performance standards and job descriptions serve as the basis for evaluations and performance goals. (*Id.* at 9).

If an evaluator finds that a teacher is not proceeding satisfactorily during an observation, the teacher must be notified within fifteen days with a "Notification of Performance Deficiency." (*Id.* at 8). The notification precedes a Plan of Assistance for serious deficiencies. A Plan of Assistance can be established if found necessary by the school district. (*Id.* at 4). "For any cause it may deem in good faith sufficient," a school district may refuse to renew a probationary teacher's contract. ORS 342.835(2).

With regard to Principal Powell's recommendation to withhold claimant's salary increment increase, the record contains no evidence explaining the proper procedure, if any, for making such a decision (unlike the evaluation process, as outlined above). The fact that Superintendent Prevenas decided not to approve the recommendation because claimant's evaluation had not been "substandard" suggests that Principal Powell's action was premature. For this reason, I tend to agree with the majority's conclusion that the recommendation was unreasonable.

Superintendent Prevenas' direction to Principal Powell to commence the evaluation process at the start of the school year, however, did not violate statute or the employee handbook. Moreover, the evaluation completed in November 1997 was preceded by the requisite number of observations; the observations also conformed with the employee handbook. The Notice of Performance Deficiency and Plan of Assistance also were completed according to the guidelines in the employee handbook. Thus, I find such actions are reasonable disciplinary, corrective or job performance evaluation actions.

Although not discussed by medical providers, claimant apparently also objected to receiving Principal Powell's December 1997 letter, the 1997 evaluation, Notice of Performance Deficiency and Plan of Assistance because she was on medical leave at the time. Although the correspondence was stressful to claimant, I find no violation of the employee handbook or physician's restriction. On the contrary, the employee handbook required the school to notify claimant of a performance deficiency within 15 working days of the observation. Consequently, it was reasonable for the school to send the correspondence to claimant.

Based on the foregoing discussion, I would not consider the parents' and students' criticism and complaints of claimant and, except for Principal Powell's recommendation to withhold the salary step increase, I also would not consider any other reasonable disciplinary, corrective or job performance evaluation actions by the employer. Consequently, I would conclude that claimant failed to carry her burden of proof and, because the majority comes to a contrary conclusion, I dissent.

In the Matter of the Compensation of
MARGARET A. BENGTSON, Claimant
WCB Case No. 96-00487
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cummins, Goodman, 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) Baker's order that: (1) set aside its December 1995 "current condition" denial as procedurally invalid under ORS 656.262(7)(b); (2) set aside its September 1996 "back-up" denial of claimant's low back injury claim; and (3) set aside the remainder of the September 1996 denial as premature under ORS 656.262(7)(a). In her brief, claimant challenges that portion of the ALJ's order that declined to assess a penalty for allegedly unreasonable denials. On review, the issues are the procedural validity of the "current condition" denial; if proper, compensability; procedural validity of the "back-up" denial; if proper, compensability; procedural validity of the September 1996 denial; if proper, compensbility; and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" and provide the following summary.

On January 9, 1995, claimant submitted an accident report stating that she slipped and fell. On April 11, 1995, claimant filed an "801" form for a back injury. In June 1995, the employer accepted a claim for "nondisabling compression fracture at L4."

After receiving medical opinion evidence that claimant did not have a compressed L4 fracture and that she sustained only a bruise during the January 1995 accident, in December 1995, the employer issued a denial of claimant's current condition. Then, in September 1996, the employer issued a denial stating that "new medical evidence now indicates that what is being claimed with regard to the residuals of the January 9, 1995, incident at work is an L3-L4 vertebral body endplate and associated marrow inflammatory response, as well as fissuring and disruption of the inferior endplate of L3." The denial further found that such conditions either "do not exist in an acute form" or were not in major part caused by the work injury and, therefore, were denied. Finally, after finding that the L4 compression fracture diagnosis was "in error," the employer revoked its acceptance of such condition and denied it.

CONCLUSIONS OF LAW AND OPINION

Procedural Validity of the "Current Condition" Denial

The ALJ found that the December 1995 denial of claimant's current condition was procedurally invalid because, when the employer issued the denial, "there was no medical opinion that there existed a combined condition comprised of claimant's previously accepted injury and a preexisting condition." Presumably, the ALJ was relying on Board cases at that time holding that, under ORS 656.262(7)(b), a carrier may issue a "pre-closure" denial when the carrier has accepted a combined condition and the denial is based on the combined condition no longer being compensable under ORS 656.005(7)(a)(B). *See, e.g., Marianne L. Sheridan*, 48 Van Natta 908 (1996).

Subsequent to the ALJ's order, we reexamined the text and context of ORS 656.262(7)(b) in *Tracy E. Blamires*, 50 Van Natta 1793 (1998), *on recon* 50 Van Natta 2273 (1998), and disavowed those Board cases holding that the statute 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, the employer's denial in the present case is procedurally proper if the medical evidence establishes that claimant's back injury combined with any preexisting condition(s). We find that the record does not support such a determination.

Before issuing its acceptance, claimant saw examining orthopedic surgeon, Dr. Neumann, and neurologist, Dr. Rich. Based on March 1995 x-rays and a May 1995 MRI, the panel diagnosed an "end-plate compression fracture on the L4 vertebra," and attributed the condition to the January 1995 accident. (Ex. 34-4).

After the employer accepted the L4 compression fracture, examining neurologist Dr. Dickerman saw claimant and reported that, based on the medical record, the January 1995 incident caused only a contusion. (Ex. 53-10). In particular, Dr. Dickerman found that claimant characteristically sought treatment for minor symptoms and her delay in seeking treatment until late March 1995 for low back symptoms indicated that the onset of low back pain did not coincide with the January 1995 event. (Ex. 59-3).

Dr. Dickerman also disagreed with the diagnosis of a compression fracture, finding that the x-ray and MRI showed only a "Schmorl's node," a preexisting and degenerative condition. (*Id.* at 11). In sum, Dr. Dickerman attributed claimant's need for treatment to a preexisting condition rather than the work incident. (*Id.*)

Examining orthopedist Dr. Thompson provided a file review and was later deposed. Dr. Thompson also found that claimant's history showed that she sought treatment for insignificant complaints; according to Dr. Thompson, because claimant saw her treating physician Dr. Cox several times after the January 1995 incident but did not report any low back pain until March 24, 1995, it was unlikely that she had the onset of low back pain at the time of the January 1995 event. (Ex. 84-5).

Additionally, Dr. Thompson did not think the MRI showed a compression fracture. (*Id.* at 7, Ex. 108-49). Instead, Dr. Thompson diagnosed a "Schmorl's node" or endplate disruption at L3, 4 and found that claimant's low back pain was "secondary to severe degenerative changes at L3, 4" and precipitated by a coughing incident. (*Id.*)

Dr. Young, radiologist, examined the imaging studies at claimant's request. He found degenerative disc disease at L3-4, including a "large Schmorl's node which invaginates through the inferior endplate of L3." (Ex. 70-2). Dr. Young also thought the condition preexisted the January 1995 incident. (*Id.* at 3). According to Dr. Young, however, there was evidence of an "acute/subacute process" or inflammation consisting of "inferior endplate infraction and disruption of the L3 vertebral body" that was "probably related to an event that occurred within the last six months to a year." (*Id.* at 4). Based on claimant's history, Dr. Young found that "the major contributing cause of [claimant's] symptoms and need for treatment is her injury of January 9, 1995[.]" (*Id.*)

In a subsequent deposition, Dr. Young explained that the May 1995 MRI showed a "Schmorl's node" herniating through the L3 endplate and that such a condition was not the same as a compression fracture. (Ex. 90-10, -11). According to Dr. Young, it would have been more accurate for the Neumann/Rich panel to diagnose an "endplate disruption at L4" and the panel had left out all findings at L3. (*Id.* 87). But Dr. Young also explained that "compression fracture" was the same as "infractions or fissures" and that the difference in terms was a matter of semantics. (*Id.* at 69, 74). He further stated that the January 1995 accident was "superimposed" on this degenerative and preexisting condition. (*Id.* at 71).

Dr. Warnock, radiologist, then examined the studies on behalf of the employer and responded to Dr. Young's report. Dr. Warnock agreed with the diagnosis of a "Schmorl's node" and a disrupted endplate and that the condition preexisted the January 1995 incident. (Ex. 89-5). Dr. Warnock disagreed with Dr. Young, however, that the MRI showed an "acute/subacute process" and that the January 1995 accident caused an endplate infraction. (*Id.* at 6). Instead, Dr. Warnock thought that "there is no question that the process at L3-4 is chronic and long standing[.]" (*Id.* at 7, Ex. 110-3).

Claimant's treating general practitioner, Dr. Cox, continued to support the diagnosis of compression fracture at L4 and thought that it was caused by the January 1995 incident. (Ex. 79-28). Dr. Cox also indicated that claimant had two "minor" compression fractures at L3 and L4. (*Id.* at 62).

Finally, claimant's treating neurosurgeon, Dr. Hacker, reported that claimant "suffered a condition of internal disc derangement as a result of her fall while performing work activities." (Ex.

109). He thought the condition "is at least 50 percent caused by her injury, although pre-existing factors such as disc degeneration may conceivably have been present." (*Id.*)

This review of the medical evidence shows that Dr. Dickerman, Dr. Thompson and Dr. Warnock thought that claimant's need for treatment was from a preexisting and degenerative condition that was unrelated to the January 1995 incident. Thus, their opinions do not support the finding that claimant had a "combined condition."

Dr. Young did find a "combined condition" in that he thought that the accident was "superimposed" on claimant's preexisting degenerative condition, resulting in an "acute/subacute process." But he also thought that the compensable injury was the major contributing cause of claimant's need for treatment. Similarly, Dr. Cox and Dr. Hacker also found that the accident was the major contributing cause of claimant's condition. Consequently, those opinions do not support the requirement under ORS 656.262(7)(b) of medical evidence showing that the "accepted injury is no longer the major contributing cause of the worker's combined condition[.]"

Therefore, because the medical opinions either do not show a "combined condition" or attribute claimant's need for treatment in major part to the compensable injury, we agree with the ALJ that the December 1995 "current condition" denial is not procedurally valid under ORS 656.262(7)(b) and we do not address compensability of claimant's "current condition."

Procedural Validity of "Back-up" Denial

ORS 656.262(6)(a) allows a carrier to revoke acceptance and issue a denial if it accepts a claim in good faith "and later obtains evidence that the claim is not compensable[.]" The requirement of "later obtained evidence" in the statute refers to new material -- that is, 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.*

Here, the employer asserts that its "later obtained evidence" consists of the reports from Drs. Dickerman, Thompson, Young, and Warnock indicating that claimant did not have a compression fracture. According to the employer, because these reports were not available until after its acceptance, such evidence satisfies the statute.

We agree that the medical opinions from these physicians were not rendered until after the acceptance and, thus, were not available to the employer at the time of acceptance. As the ALJ noted, however, the opinions from these physicians for the most part relied upon the same information available to the employer when it accepted the L4 compression fracture. *See Greenbriar AG Management v. Lemus*, 156 OR App 499 (1998). Specifically, the physicians essentially rely on the May 1995 MRI in determining that the more appropriate diagnosis is "Schmorl's node" or "endplate disruptions" and that claimant does not have a "classic" compression fracture. This is the same study that the Neumann/Rich panel relied upon in diagnosing the compression fracture. Thus, we consider the medical opinion reports generated after the acceptance as constituting a reevaluation of the existing evidence rather than "later obtained evidence."[1] Consequently, we conclude that the "back-up" denial is procedurally invalid and we need not address whether the employer carried its burden of showing that the accepted condition is not compensable.

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[1] The employer also vigorously disputes the ALJ's finding that claimant testified "in a sincere and credible manner." According to the employer, claimant's testimony was not consistent with her statements to an investigator and she inconsistently reported her history to medical providers. The employer asks us to "reverse" the ALJ's credibility finding.

We find it unnecessary to address the credibility issue in deciding the propriety of the "back-up" denial. When the employer decided to accept the L4 compression fracture, the records showing claimant's medical history were available to it. These records showed that claimant previously had suffered low back pain, she sought treatment for minor ailments, and she saw her treating physician numerous times after the January 1995 incident before she reported low back pain and the accident to her doctor. Despite such evidence, the employer accepted the L4 compression fracture. Because such evidence was available at the time of acceptance, it does not constitute "later obtained evidence" for purposes of the "back-up" denial. *Greenbriar AG Management*, 156 Or App at 499. Thus, whether or not claimant is credible, such a finding does not help the employer in proving that its "back-up" denial was *procedurally* proper.

Denial of Other Conditions

The September 1996 denial recited that "new medical evidence" indicated that "what is being claimed with regard to the residuals of the January 9, 1995, incident at work is an L3-L4 vertebral body endplate and associated marrow inflammatory response, as well as fissuring and disruption of the inferior endplate of L3." The employer then denied "these noted conditions." The ALJ set aside this portion of the denial as a "premature nullity" because claimant did not "clearly request formal written acceptance" of the conditions, as required under ORS 656.262(7)(a).[2] The employer contends that claimant did not challenge the denial as premature until its reply during closing argument and, therefore, the issue was not timely raised and the ALJ erred in addressing it.

At hearing, claimant's attorney asserted that claimant was entitled to compensation for "the disruption or collapse or however you want to call it -- the L3-4 disc, the -- and also the L3-L4 fissuring." (Tr. 3). At the completion of testimony, the ALJ stated this "[t]his will conclude the recorded proceedings, we'll discuss form and time of argument momentarily." (Tr. 244). After the hearing, the employer submitted an "opening argument," which was followed by claimant's "opening argument." The employer then provided a "response." Claimant submitted a "reply argument" where, for the first time, she raised ORS 656.262(7)(a), asserting that the September 1996 denial was premature because claimant had not requested formal written acceptance of the L3 condition. In its "reply," the employer did not challenge the timeliness of claimant's contention or seek further development of the record, but rather asserted that its denials should be upheld. Thereafter, claimant provided a "closing argument." In his Opinion and Order, the ALJ stated that the hearing was held on a specific date and "closed...upon receipt of final correspondence."

We have consistently held that we will not consider issues raised for the first time in closing argument at the hearing. *See, e.g., Lawrence E. Millsap*, 47 Van Natta 2112 (1995). (1989). We do so based on the notion that fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if the issue is raised after the record closes. *See Donald A. Hacker*, 37 Van Natta 706 (1985). Furthermore, when parties litigate an issue by implicit agreement, that issue properly is considered by the ALJ. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the Referee and Board not to decide that issue).

Here, we need not resolve the question of whether claimant's procedural challenge to the employer's denial was raised during closing argument because, under the circumstances of this case, we find no error in the ALJ's decision to consider the merits of claimant's argument. In responding to claimant's procedural challenge, the employer neither objected to the "issue" nor sought to further develop the record. Instead, the employer challenged the merits of claimant's argument. Because the ALJ also addressed the merits of claimant's procedural challenge to the employer's denial, we consider the parties to have implicitly agreed to litigate the issue.

Turning to the merits, there is no dispute that claimant did not request a formal written acceptance of any condition or otherwise "communicate in writing" to the employer any objections about the notice of acceptance. Consequently, we agree with the ALJ that the employer's denial of "an L3-L4 vertebral body endplate and associated marrow inflammatory response, as well as fissuring and disruption of the inferior endplate of L3" is a nullity with no legal effect. *See Vicki L. Davis*, 49 Van Natta 603 (1997).

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

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

In setting aside part of the employer's September 1996 denial as null, however, we emphasize that we do not address claimant's argument that the employer's acceptance of an L4 compression fracture includes the diagnosis of "L4 vertebral body end-plate." Moreover, because we have set aside the December 1995 and September 1996 denials on the ground that they are not *procedurally* valid, the employer's acceptance of "compression fracture at L4" is undisturbed. That means that our order has not addressed the merits of any additional condition or diagnosis.

Penalties and Attorney Fees

Claimant continues to assert that both of the employer's denials were unreasonable and, therefore, she is entitled to penalties.

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.*

We agree with the ALJ that the employer had "legitimate doubt" when it issued both denials. After the acceptance, the employer obtained medical evidence that the L4 compression fracture was a misdiagnosis and that claimant had a preexisting degenerative condition. When the employer issued the December 1995 "current condition" denial, the Board had referred to ORS 656.262(7)(b) in only one case, deciding that it was not necessary to determine its application. *See Donald W. Crabb*, 47 Van Natta 2313 (1995). Consequently, in the absence of such statutory construction, we do not consider it unreasonable for the employer to have relied on ORS 656.262(7)(b), along with the medical opinion that claimant's need for treatment was caused by a degenerative condition, in issuing its December 1995 denial.

The medical opinion evidence also gave the employer a basis for finding that "later-obtained evidence" showed that claimant's compensable condition was not compensable. Thus, we find that the employer also had a "legitimate doubt" as to its liability for the accepted condition.

Finally, there is no basis for awarding a penalty for any condition different from the accepted L4 compression fracture because, as previously explained, we have not addressed or found those conditions compensable. Thus, whether or not the employer's denial of "an L3-L4 vertebral body endplate and associated marrow inflammatory response, as well as fissuring and disruption of the inferior endplate of L3" is unreasonable, there are no "amounts then due" for awarding a penalty.

In sum, we conclude that the employer's December 1995 and September 1996 denials do not warrant a penalty.

Claimant's attorney is entitled to an assessed fee for services on review because the employer initiated review and we have found that claimant's compensation should not be disallowed or reduced. 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 denials is $5,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the high complexity of the issues, the substantial values of the interests involved, and (considering the vigorous defenses asserted by the employer) the significant risk that claimant's counsel might go uncompensated for services rendered on review regarding these issues.[3] We further note that claimant is not entitled to an attorney fee for her counsel's unsuccessful efforts on review regarding the penalty issues.

ORDER

The ALJ's order dated February 20, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $5,000, to be paid by the self-insured employer.

[3] The record consists of approximately 110 exhibits and a 244 page transcript. Claimant also submitted a 96 page respondent's brief in response to the employer's 61 page appellant's brief (the employer also filed a 53 page reply brief).

In the Matter of the Compensation of
TED L. GOLDEN, Claimant
WCB Case Nos. 98-01162 & 97-06378
CORRECTED ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

It has come to our attention that our December 17, 1998 Order on Review contains a clerical error. Specifically, a portion of the first paragraph on page 6 was inadvertently omitted from at least one party's counsel's copy of the order.

To correct this oversight, our December 17, 1998 order is withdrawn and replaced with the following order. The parties' rights of appeal shall begin to run from the date of this order.

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.

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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.

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.

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
CAROL E. BROWN, Claimant
WCB Case No. 98-00791
ORDER ON REVIEW
Rodolfo A. Camacho, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's bilateral upper extremity condition; and (2) awarded claimant's attorney an assessed fee of $3,200 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. On review, the issues are compensability, remand and attorney fees.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second full paragraph on page 2, we replace the seventh sentence with the following:

> "Dr. Jewell reported that claimant had electrical abnormalities of the median nerve as noted by nerve conduction testing, but he did not find clinical correlation to substantiate that she had carpal tunnel syndrome that would require surgery. (Ex. 16-2). He said claimant appeared to have some sleep and mood disorder problems. (*Id.*)"

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $3,200. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4), in failing to draw conclusions from those facts, and in failing to demonstrate how he weighed those conclusions in determining the amount of an attorney fee. SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award.

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 Supreme Court's entire decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

Here, the ALJ simply ordered SAIF to pay an "assessed fee in the amount of $3,200." Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), 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 2330.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The record contains no statement of services documenting the time claimant's attorney spent on the case. The issue was compensability of claimant's bilateral upper extremity condition. The hearing lasted 45 minutes. Claimant testified on her own behalf. The record contains 32 exhibits, two of which were submitted by claimant's attorney. There were no depositions.

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. Because claimant's bilateral upper extremity condition 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $3,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. 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, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated August 26, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

January 14, 1999 Cite as 51 Van Natta 59 (1999)

In the Matter of the Compensation of
ROBERT H. LOE, Claimant
Own Motion No. 98-0438M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On December 18, 1998, we abated our November 19, 1998 Own Motion Order in which we declined to reopen claimant's 1982 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. The SAIF Corporation has neither responded nor opposed claimant's submission and contentions. After completing our reconsideration, we withdraw our prior order and replace it with 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 initially contended that claimant was not in the work force because he had not responded to its various requests for proof of earnings. In response to our previous order finding that he was not in the work force, claimant asserts that he was and remains employed. In support of that contention, claimant has submitted copies of his 1997 W-2 forms and December 1998 paycheck stub. Based on this unrebutted submission, we are persuaded that, at the time of his current disability, claimant was engaged in regular gainful employment and remained in the work force.

Accordingly, in lieu of our December 18, 1998 order, 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.

In the Matter of the Compensation of
GARY S. FOX, Claimant
WCB Case No. 97-08382
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl, Haynes, and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that assessed a penalty for SAIF's allegedly unreasonable claim processing. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Stipulated Findings" and "Findings of Fact," and we make the following additional finding. The August 19, 1997 Opinion and Order awarded claimant a total of 51 percent unscheduled permanent disability for the low back.

CONCLUSIONS OF LAW AND OPINION

SAIF suspended payment of claimant's permanent partial disability (PPD) benefits during his participation in an ATP. The ALJ concluded that this action was unreasonable and assessed a 25 percent penalty against SAIF under ORS 656.262(11)(a). The suspended benefits were awarded under a final Opinion and Order issued by a prior ALJ.

When the hearing in this matter convened, claimant had completed the ATP program. Accordingly, payment of those previously suspended benefits is a moot issue, and the issue at hearing, as well as on review, is limited to claimant's request for a penalty for SAIF's allegedly unreasonable claim processing.

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. 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). 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).

In assessing a penalty, the ALJ rejected SAIF's argument that ORS 656.268(9) provided a reasonable basis for its suspension of claimant's PPD benefits. This statutory provision provides in pertinent part:

> "If, *after the determination made* or notice of closure issued *pursuant to this section*, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, *any permanent disability payments due under the*

> *determination* or closure *shall be suspended,* and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training[.]" (Emphasis supplied).

The ALJ rejected SAIF's argument that PPD awarded by an ALJ is encompassed in the statutory language "*permanent disability payments due under the determination.*" The ALJ, instead, concluded that the text and context of the statute unambiguously established the legislature's intent to only allow suspension of PPD benefits awarded by Department determination order or carrier notice of closure.

On review, SAIF argues that its construction of ORS 656.268(9) is reasonable because it is consistent with sound legislative and administrative policy.[1] In addition, SAIF relies on the Board's prior decisions in *Charles C. Tackett,* 31 Van Natta 65 (1981) and *Minnie A. Daniel,* 35 Van Natta 681 (1985).

A carrier's reasonable reliance on a statutory provision or legal decision can establish a legitimate doubt regarding its legal liability. *Norgard v. Rawlinsons and New System Laundry,* 30 Or App 999 (1977). Here, we conclude that the rationale expressed in the *Tackett/Daniel* decisions provided a reasonable basis for SAIF's suspension of claimant's PPD benefits during his ATP.

In *Tackett,* the Board construed *former* ORS 656.268(5), which provided as follows:

> "If, *after the determination made pursuant to subsection (3) of this section,* the director authorizes a program of vocational rehabilitation for an injured worker, any *permanent disability payments due under the determination* shall be suspended, and the worker shall receive temporary disability compensation while he is enrolled in an authorized vocational rehabilitation program[.]" (Emphasis supplied).

The *Tackett* Board acknowledged that the language "permanent disability payments due under the determination" referred only to an award of permanent disability made by a Determination Order. Nevertheless, the Board ultimately concluded that the carrier in *Tackett* had the authority to suspend payment of a Referee's award of PPD benefits during the claimant's participation in an ATP. In reaching that decision, the Board reasoned that the legislature's intent in enacting *former* ORS 656.268(5) would be served by the suspension of a Referee's award of PPD benefits during an ATP. *Accord Minnie A. Daniel,* 35 Van Natta 681 (1985) (Board adheres to rationale in *Tackett* and approves carrier suspension of Referee's award of PPD during ATP program).

While *Tackett* and *Daniels* construed an earlier version of ORS 656.268(9), given the similarity between the present and earlier versions of the statute, we conclude that the *Tackett/Daniel* decisions provided a reasonable basis for SAIF's suspension of claimant's PPD benefits. Moreover, we note that there has been no case since *Tackett* and *Daniel* that has interpreted *amended* ORS 656.268(9). SAIF could, therefore, reasonably rely on those decisions in suspending PPD pending claimant's completion of the ATP.

In so concluding, we reject claimant's argument that SAIF cannot avoid a penalty because it did not specifically rely upon these decisions at hearing. Although *Tackett* and *Daniel* were not cited at hearing, SAIF is presumed to be aware of established case law. Moreover, claimant cites no case authority that requires a carrier's claim processing decision to be expressly premised on case precedent. Under such circumstances, as long as case law exists that could reasonably justify a carrier's claim processing, and in the absence of subsequent contrary case precedent construing the current statutory provision, we decline to find SAIF's conduct to have been unreasonable.

On this record, we conclude that the *Tackett/Daniel* decisions provided a legitimate basis for SAIF's suspension of claimant's PPD benefits during the ATP. Consequently, SAIF's claim processing was not unreasonable, and claimant is not entitled to a penalty or penalty-related fee.[2]

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[1] Specifically, SAIF argues that suspension of PPD benefits awarded by an ALJ eliminates simultaneous temporary disability and permanent disability benefits, and reduces overpayment of permanent disability to which a claimant may not be entitled after completion of the ATP.

[2] In so concluding, we take no position regarding the continued vitality of *Tackett* and *Daniel* reasoning. We would point out, however, that the legislature may wish to address the possible ambiguity in ORS 656.268(9) and definitively state whether "determination" is limited to Determination Orders or whether it also includes, for example, permanent disability awards granted by a reconsideration order, an ALJ order, or a Board order.

ORDER

The ALJ's order dated April 9, 1998 is reversed. The ALJ's assessment of a penalty is reversed.

In the Matter of the Compensation of
MARGARET J. FRANKS, Claimant
WCB Case Nos. 98-04143 & 98-04140
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) awarded a $5,000 attorney fee under ORS 656.386(1); and (2) assessed a $1,000 "penalty-related" attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable denial of claimant's December 5, 1997 injury claim. SAIF requests remand for admission of evidence regarding an appropriate ".386(1)" attorney fee. Claimant cross-requests review of that portion of the order that did not award a "penalty-related" attorney fee for SAIF's allegedly unreasonable denial of her February 11, 1998 injury claim. In addition, claimant submits "post-hearing" documents and argues that SAIF's appeal of the ".386(1)" attorney fee was frivolous and/or filed for the purpose of harassment. On review, the issues are remand, sanctions, and attorney fees. We deny the motions for remand and sanctions, reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

With her brief, claimant submits two "post-hearing" letters from her attorney to SAIF and an affidavit summarizing his "post-hearing" attempts to negotiate a mutually agreeable attorney fee for prevailing against SAIF's denials of her December 5, 1997 and February 11, 1998 injury claims. Claimant contends that these documents support a conclusion that SAIF's appeal of the ALJ's ".386(1)" attorney fee was frivolous or filed for the purpose of harassment[1] (apparently because SAIF chose to appeal the fee award to the Board rather than negotiate it with claimant's counsel).

We agree with SAIF that the ALJ's fee award was excessive and we modify it accordingly. Therefore, we need not address claimant's motion for sanctions.

We acknowledge SAIF's request for remand to the ALJ for admission of additional evidence relevant to the determination of an appropriate attorney fee. We deny SAIF's motion to remand, because we do not find the record to be improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). Thus, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it would be unnecessary to remand this case to the ALJ for supplementation of findings regarding claimant's attorney fee award. *See Sherlie A. Dial*, 50 Van Natta 1405 (1998).[2]

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[1] ORS 656.390(1) gives the Board authority to impose an appropriate sanction against an attorney who filed a frivolous request for review or one "filed in bad faith or for the purpose of harassment." "Frivolous" 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 (1992) (defining "frivolous" under former ORS 656.390).

[2] We also acknowledge claimant's request that SAIF be required to submit a portion of Exhibit 1 "without the date cut off." (Claimant's Brief, pp. 7-8, n.2). We treat claimant's request as a motion to remand for admission of additional evidence. Because a dated version of Exhibit 1 would not likely affect the outcome of this case, remand is inappropriate and claimant's motion is denied.

Attorney Fees

Claimant suffered a compensable strain of the "right pelvic attachment" on December 5, 1997 and a similar left-sided compensable strain on February 11, 1998. The ALJ assessed "penalty-related" attorney fees for discovery violations under both claims. SAIF does not challenge those fee assessments.

The ALJ also assessed a penalty-related attorney fee, based on a finding that SAIF's denial of the 1997 claim was unreasonable. On review, SAIF argues that its denial was reasonable.[3]

The ALJ declined to assess an attorney fee for SAIF's allegedly unreasonable denial of the 1998 claim. On review, claimant argues that a fee should be assessed on that basis.

Claimant may be entitled to attorney fee awards under ORS 656.382(1) if SAIF unreasonably delayed or resisted payment of compensation under one or both claims. However, the parties do not dispute the ALJ's statement that there is no evidence of compensation "owing to claimant." (Opinion and Order, p. 6). We also find no evidence of unpaid compensation under either claim at any time. Consequently, there is no proof of resistance to the payment of compensation that would authorize the assessment of a penalty-related attorney fee under ORS 656.382(1). *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Aetna Casualty Co. v. Jackson*, 108 Or App 253 (1991); *Dennis J. Burns*, 50 Van Natta 2136 (1998). Accordingly, the ALJ's $1,000 penalty-related attorney fee under the 1997 claim is reversed and claimant is not entitled to an assessed attorney fee under the 1998 claim (even if SAIF's denial was unreasonable).

The ALJ awarded a $2,500 attorney fee for services related to prevailing over SAIF's denial of claimant's December 5, 1997 injury claim and a $2,500 attorney fee for services related to prevailing over SAIF's denial of claimant's February 11, 1998 injury claim. The ALJ considered the factors in OAR 438-015-0010(4), "including that the dispute in this case was primarily factual, that it was not medically or legally complex and that there were no depositions and a straightforward medical record." (Opinion and Order, p. 6).

Claimant contends that the ALJ's fee award was reasonable because the case was tried some distance from Portland (in The Dalles) and it involved two separate claims. SAIF contends that the fee award was not reasonable.

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).

Nonetheless, because SAIF has now advanced arguments challenging the sufficiency of the ALJ's order and the amount of the fee awarded (and because further appellate review of our decision would be subject to the "range of discretion" criteria discussed in *Schoch*), we determine the attorney fee amount as follows.

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.

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[3] SAIF contends that we should not consider claimant's arguments about the reasonableness of the denial (beyond its reference to claimant's knee) because claimant did not raise these arguments at hearing. (*See* Tr. 9). But the ALJ addressed the substantive reasonableness of the denial (*i.e.*, SAIF's then-current contention that claimant filed the 1997 injury claim in retaliation for being fired) and our *de novo* authority encompasses all issues considered by the ALJ. *See Destael v. Nicolai*, 80 Or App 723 (1986) (The scope of our *de novo* review encompasses all issues considered by the ALJ); *Kenneth L. Devi*, on recon, 49 Van Natta 108, 109 (1997) (same); *see also* OAR 438-006-0031.

Our review of the record reveals the following information. The issues in dispute were the compensability of claimant's December 5, 1997 and February 11, 1998 injury claims and the reasonableness of SAIF's denials (as well as discovery-related penalty issues).

Approximately 10 exhibits were received into evidence, with at least 3 generated and submitted by claimant. The hearing lasted about an hour and 45 minutes, with a transcript consisting of approximately 51 pages. Three lay witnesses testified, including claimant.

As the ALJ noted, the case was not medically or legally complex. The record indicates that medical services were limited to three doctor visits. On these bases, we find that the claims' value is lower, and the benefits secured less than those generally encountered by this forum. 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 record 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 $3,000 is a reasonable attorney fee for claimant's counsel's services at the hearings level related to prevailing over both denials. In reaching this conclusion, we have particularly considered the time devoted to the compensability issues (as represented by the record), the complexity of the issues, the value of the interests involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated. The ALJ's $5,000 attorney fee award is modified accordingly.

ORDER

The ALJ's order dated August 26, 1998 is reversed in part, modified in part, and affirmed in part. That portion of the order that directed the SAIF Corporation to pay a $1,000 assessed attorney fee under ORS 656.382(1) is reversed. Those portions of the order that assessed attorney fees for setting aside SAIF's denials of claimant's December 5,1997 and February 11, 1998 injury claims are modified. In lieu of the ALJ's $5,000 attorney fee award, claimant is awarded a fee of $3,000 for prevailing over both denials, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
THEODORE W. LAWPAUGH, Claimant
WCB Case No. 97-0255M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's compensable low back strain injury. Claimant's aggravation rights expired on October 22, 1992. SAIF denied the compensability of claimant's current L4-5 condition, and claimant filed a request for hearing with the Hearings Division regarding that denial. (WCB Case No. 97-05276). In addition, SAIF recommended against reopening on the grounds that SAIF is not responsible for claimant's current condition.

On July 9, 1997, we postponed action on the own motion matter pending resolution of the litigation regarding the compensability issue. On September 4, 1998, Administrative Law Judge (ALJ) Hazelett issued an order that upheld SAIF's denial. Claimant requested Board review of ALJ Hazelett's order and, by an order issued on today's date, the Board affirmed ALJ Hazelett's order. *Theodore W. Lawpaugh*, 50 Van Natta 65 (1999). Because the compensability issue has been resolved, we proceed with our consideration of the own motion matter.

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, we may authorize 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 without authority to authorize payment of temporary disability compensation. In this regard, it has been determined that, although claimant underwent low back surgery, the need for that surgery was not related to the compensable 1987 low back strain injury. In other words, there was no worsening of the compensable injury that required surgery or hospitalization, which is a prerequisite under ORS 656.278(1)(a) for own motion relief. Therefore, we must deny claimant's request for temporary disability compensation.

IT IS SO ORDERED.

In the Matter of the Compensation of
THEODORE W. LAWPAUGH, Claimant
WCB Case No. 97-05276
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's partial denial of his L4-5 low back condition claim. On review, the issue is compensability.

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

Claimant contends that his current low back condition at L4-5 is compensable. He argues that he had never experienced back pain before the July 6, 1987 work injury. But the medical record clearly does not support this contention. In this regard, before July 1987, claimant underwent several periods of conservative treatment for low back strains related to twisting or bending. (Exs. 3, 4, 5, 6, 7, 8, 9, 10, 11). In addition, claimant's May 2, 1983 treatment involved bilateral low back pain with radiation into the posterior thigh. (Ex. 6).

Claimant has the burden of proving compensability of the L4-5 condition by a preponderance of the evidence. ORS 656.266. In addition, given the passage of time between the 1987 injury and the 1996 surgery, the degenerative conditions, and the 1988 and 1996 MRI findings, the issue of the contribution of claimant's compensable low back strain injury to his current L4-5 condition is a complex medical question, the resolution of which requires medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986). Therefore, claimant's lay opinion regarding causation is not sufficient. However, claimant need not demonstrate medical causation to a scientific certainty. *Hutcheson v. Weyerhaeuser*, 288 Or 51 (1979); *Ford v. SAIF*, 71 Or App 825, *rev den* 299 Or 118 (1985). The appropriate measure of certainty in a workers' compensation claim is reasonable medical probability. *Coday v. Willamette Tug & Barge*, 250 Or 39, 47 (1968).

When medical evidence is divided, we generally give greater weight to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Furthermore, in evaluating medical opinions, we give weight to those that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259 (1986).

Here, we agree with the ALJ that there are persuasive reasons not to defer to the opinion of Dr. Tahir. Moreover, we need not determine whether claimant must prove compensability of the L4-5 condition under the material contributing standard or the major contributing standard because Dr. Tahir's opinion fails under either standard.

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[1] Although represented by counsel at hearing, claimant is not represented on review.

Dr. Tahir makes several unexplained changes of opinion. First, he stated, without explanation, that claimant's L4-5 disc herniation was due to the 1987 work injury. (Ex. 54). Then he stated that he did not know the cause of the L4-5 disc herniation. (Exs. 63, 65). Finally, in his deposition, he stated that it was still his opinion that the L4-5 disc herniation was the result of the 1987 work injury. (Ex. 66-5). *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of opinion renders physician's opinion unpersuasive).

In his deposition, Dr. Tahir could not explain his opinion beyond stating that claimant's pain was located on the right side in 1987 and 1996, claimant had problems since the 1987 injury, and he had an opportunity to observe the anatomy of the injury during the 1996 surgery. (Ex. 66-8). Dr. Tahir did not explain what anatomy he observed during surgery that lead to his opinion that the 1987 injury caused a L4-5 disc herniation that first appeared in 1996. He stated that he found calcification of disc material in surgery but did not address it in his operative report because it was "CT scan calcification, not with the naked eye calcification." (Ex. 66-11). But, as noted by Dr. Dickerman, who performed a record review for SAIF, the 1996 CT scan showed soft tissue material at L4-5, not calcified material. (Exs. 34, 59-5).

Furthermore, the radiologist who performed the 1996 MRI and Dr. Dickerman compared the 1988 MRI and the 1996 MRI and determined that the L4-5 disc herniation was a new condition that occurred after the 1988 MRI. (Exs. 31, 59-7). Dr. Dickerman opined that the 1988 MRI showed that one year after the compensable injury there was no significant involvement of the L4-5 disc, which would not be medically probable if claimant had injured the L4-5 disc in 1987. (Ex. 59-7). Dr. Tahir did not address this, stating that he did not remember if he reviewed the 1988 MRI. (Ex. 66-11).

Given all of these problems with Dr. Tahir's opinion, we agree with the ALJ that claimant failed to meet his burden of proof.

ORDER

The ALJ's order dated September 4, 1998 is affirmed.

In the Matter of the Compensation of
JAN MOHAMMAD, Claimant
WCB Case No. 98-03309
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, MacKenzie, 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 insurer's denial of his aggravation claim for a low back condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order with the following modification and supplementation. We do not adopt paragraphs four, five and eight of the ALJ's "Findings of Fact." We now supplement the ALJ's order as follows.

The ALJ upheld the insurer's denial of claimant's aggravation claim, finding that claimant had failed to prove that his compensable low back condition had "actually worsened." *See* ORS 656.273(1). On review, claimant contends that the medical evidence establishes that his compensable low back condition has worsened. Therefore, claimant asserts that the ALJ should have set aside the insurer's aggravation denial. We disagree.

Under ORS 656.273(1), a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. Two elements are necessary under the statute to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995); *see also Intel Corporation v. Renfro*, 155 Or App 447 (1998) (holding that a claimant must prove diminished wage-earning capacity in order to prove a worsened condition involving an unscheduled body part under ORS 656.273(1)). If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7)(a).[1] *Gloria T. Olson*, 47 Van Natta at 2350.

We begin our analysis with a determination of whether claimant's current low back condition is a compensable condition. As a result of the compensable August 20, 1993 injury, the employer accepted a low back strain. (Ex. 7). Drs. Udarbe and Delashaw have diagnosed claimant's current condition as a disc herniation at L5-S1. (Exs. 109, 113). Claimant's L5-S1 disc herniation is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the L5-S1 disc herniation is a compensable condition. *See Gloria T. Olson*, 47 Van Natta at 2350.

Dr. Delashaw opined that it was just as likely that the disc herniation was due to a noncompensable degenerative condition as it was to the compensable injury. Moreover, Dr. Delashaw indicated that there was no way of knowing with any degree of certainty which was the greater cause. (Ex. 114). Dr. Udarbe opined that claimant's disc herniation had worsened, but he did not explain how the disc herniation was related to the 1993 injury when he answered "yes" to the compound question of whether claimant's current low back condition was related in major or material part to the original compensable injury. (Ex. 113).

Based on our *de novo* review of medical evidence from the two physicians who diagnosed a herniated disc, we are not persuaded that it proves that the L5-S1 disc herniation is a compensable condition.[2] Accordingly, we agree with the ALJ's decision to uphold the insurer's aggravation denial.

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[1] Claimant asserts that the insurer's denial was limited to the defense that claimant's low back condition had not worsened. (Ex. 111). Even assuming that claimant's assertion is true, the insurer's counsel raised a causation issue at hearing. (Ex. 8). Claimant's counsel did not object to the insurer's amendment of its denial to raise causation as an issue. *See Alan T. Spaeth*, 48 Van Natta 1585, 1588 n. 1 (1996) (Given the lack of objection to a carrier's attempt to raise a compensability defense, an implied agreement existed to try a compensability issue); *Michael A. Beall*, 48 Van Natta 487, 487 (1996) (where the parties tried the issue of whether the claimant's injury occured in the course of his employment by implicit agreement, *i.e.*, without objection, the issue was properly before the ALJ).

[2] We need not determine whether a major causation standard applies because we do not find the medical evidence persuasive under either standard.

ORDER

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

In the Matter of the Compensation of
JOHN NIELSEN, Claimant
WCB Case No. 98-02859
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's injury claim for a right shoulder condition; and (2) assessed a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We change finding of fact #3 to read:

Mr. Culmer, claimant's supervisor, was working with claimant on March 3, 1998. (Tr. 25). Claimant was working on the garage and Mr. Culmer was setting up a patio in the back. (*Id.*) Although claimant testified that on March 3, 1998 he had told Mr. Culmer that he hurt his shoulder (Tr. 10, 18), Mr. Culmer testified that he did not recall that claimant told him that he had hurt his shoulder or arm on that day. (Tr. 27). Mr. Culmer said: "If he did, it was all in casual conversation, basically just like somehow I'm hurt, but nothing was really brought to my attention." (*Id.*) Mr. Culmer said claimant seemed to be performing "just fine" on the day of the injury, but he acknowledged that he had not seen claimant much during the last two hours of the day, when the injury occurred. (*Id.*) Later in questioning, Culmer explained:

> "If anything was brought up, it was brought real casually. In the construction trade, he thought he could speed up and you're always complaining of one thing or another. And nobody ever makes any mind of it, you know." (Tr. 29, 30).

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusion regarding compensability.

Penalties

The ALJ found that there was no evidence that claimant had a preexisting condition and, therefore, the employer's denial based on a "worsening" was unreasonable. The ALJ also found that the employer's witness did not provide any evidence that casted doubt on claimant's story. The ALJ noted that the law on "objective findings" had been well settled and the employer's denial, based on the record and the case law, was unreasonable.

The employer argues that it had a legitimate doubt as to compensability of the claim and, therefore, claimant is not entitled to a penalty.

A carrier is liable for a penalty if it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." 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.*

On April 7, 1998, the employer denied the claim, asserting that the claim was not substantiated by objective findings related to the alleged injury, and also stating that it did not appear claimant's condition was worsened by or arose out of and in the course of his employment. (Ex. 7).

There were no witnesses to claimant's injury on March 3, 1998. (Ex. 5A-4, Tr. 9). In a statement to the employer on March 27, 1998, claimant said that he had reported his injury to Mr. Culmer on March 3, 1998, right after it happened. (Ex. 5A-13, -22). The employer had information that Mr. Culmer was not aware that claimant had been injured on March 3, 1998 and that claimant did not appear to be affected by any injury when he left work on that day. Under these circumstances, we conclude that the employer had a legitimate doubt regarding its liability for claimant's injury.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated August 6, 1998 is reversed in part and affirmed in part. That portion of the ALJ's order assessing a penalty is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
HONEY L. WEBBER, Claimant
WCB Case No. 98-03730
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that assessed a penalty for an allegedly unreasonable denial. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," modified as follows. The contract between the employer and its landlord provides that, in the event that the landlord fails to comply with its obligations concerning maintenance of certain portions of the parking lot, "and such failure creates an emergency situation," the employer could perform the necessary "maintenance and repairs...upon prior written notice" to the landlord.

CONCLUSIONS OF LAW AND OPINION

The ALJ first decided that claimant's right wrist injury was in the course, and arose out, of claimant's employment. Furthermore, the ALJ found no "meaningful distinction between" *Montgomery Ward v. Cutter*, 64 Or App 759 (1983), and the facts of this case and, thus, assessed a penalty based on an unreasonable denial. The employer requests review only of that portion of the order assessing a penalty.

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.*

In *Cutter*, the court addressed compensability of a worker's injury from falling in a shopping center parking lot. The worker, who was employed in a store located in the shopping center, was returning to work after a lunch break. Although the mall owners provided regular maintenance and supervision of the parking lot, the employer paid a common area fee for those services and could require the owners to make repairs.

The court decided that the claimant's injury was in the course and scope of the employment. In coming to this conclusion, the court reasoned that, because the worker was injured in a portion of the parking lot where she was required to park and the employer could have required the shopping mall to repair the hole, that portion of the parking lot where the claimant was injured was sufficiently within employer's control to be treated as part of its premises. 64 Or App at 762-63.

Although the facts in this case are similar to *Cutter*, we find this case sufficiently distinguishable to find that the employer had "legitimate doubt." Namely, the contract here allowed the employer to make repairs only in an "emergency situation." That fact shows a different level of control than the employer in *Cutter*, where the contract provided that it "could require the owners to make repairs." We further note the absence of any Board or court case addressing whether an injury is in the "course and scope" of employment under a contract with the terms at issue here.

In sum, having found that the employer had a "legitimate doubt" as to its liability, we conclude that the denial was not unreasonable and claimant is not entitled to a penalty.

ORDER

The ALJ's order dated August 21, 1998 is reversed in part. That portion of the order that assessed a penalty for an unreasonable denial is reversed.

In the Matter of the Compensation of
ALFREDO R. HERNANDEZ, Claimant
WCB Case No. 97-10169
ORDER ON REVIEW
Max Rae, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by the Board *en banc*.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded temporary partial disability (TPD) for the period of November 21, 1997 to March 20, 1998, payable at the temporary total disability (TTD) rate. Claimant cross-requests review of that portion of the ALJ's order that declined to award penalties for SAIF's allegedly unreasonable refusal to pay temporary disability after November 20, 1997. On review, the issues are entitlement to temporary disability, rate of temporary disability, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the parties' "Stipulated Facts."

CONCLUSIONS OF LAW AND OPINION

This case concerns a complex issue of entitlement to temporary disability. To assist the reader, we begin with a brief summary of the relevant facts.

On November 16, 1997, claimant compensably injured his left foot while working as a Christmas tree harvester for the employer. Dr. Stringham, claimant's attending physician, authorized TTD through November 17, 1997. Dr. Stringham then approved modified employment that was available at the same hours and wages as the job at injury, but only for the period from November 21, 1997 through December 15, 1997, when the Christmas tree harvest ended. Modified work was not available after December 15, 1997.

The employer would have offered the physician-approved modified job to claimant, except that claimant was unable to produce proof that he possessed a valid Social Security number after the validity of the number presented at hire was questioned. For purposes of this case only, claimant has waived the opportunity to contest SAIF's allegation that, for all periods for which temporary disability is sought, he has been a person present in the United States in violation of federal immigration laws, *i.e.*, an "illegal alien."

Claimant's average weekly wage before injury was $270.00. His weekly TTD rate is $180.01. SAIF paid claimant TPD at the full TTD rate for November 19 and 20, 1997, in the total amount of $72.00. SAIF has paid no other disability compensation. Claimant filed a request for hearing on his entitlement to temporary disability benefits after November 20, 1997 and the rate at which those benefits should be paid. At the time of hearing, claimant had not reached medically stationary status, nor had he been released to regular work. Claimant has earned no wages since he left work on November 16, 1997, the date of the compensable injury.

At hearing, claimant contended that he was entitled to temporary disability after November 20, 1997 pursuant to ORS 656.325(5)(c), which concerns payment of temporary disability to individuals present in the United States in violation of federal immigration laws. SAIF disputed claimant's entitlement to additional temporary disability. SAIF relied on the provisions of ORS 656.325(5)(c) and the administrative rule (OAR 436-060-0030(7)) that provides the mechanism for calculating temporary disability for "illegal aliens."

The ALJ concluded that ORS 656.325(5)(c) and 656.212(2) required the employer to pay TPD benefits to claimant whether or not a modified job was available for claimant to perform. In calculating claimant's rate of temporary disability benefits, the ALJ concluded that OAR 436-060-0030(7) exceeded the Director's rulemaking authority and was, therefore, invalid. Instead, the ALJ calculated the amount

On review, SAIF contends that the ALJ incorrectly determined that OAR 436-060-0030(7) was invalid and that, because his treating physician released him to a modified job with wages equal to the job at injury, claimant is entitled to TPD at the rate of zero pursuant to that administrative rule. For the following reasons, we agree with SAIF.

Entitlement to Temporary Disability

We first examine claimant's general entitlement to temporary disability. We begin our analysis with an evaluation of the text and context of the applicable statute. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993) (providing methodology for statutory interpretation).

ORS 656.325(5) provides in part:

"Notwithstanding ORS 656.268:[1]

" * * * * *

"(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payment pursuant to ORS 656.212 when the attending physician approves employment in a modified job *whether or not such a job is available.*" (Emphasis added).

In contrast to ORS 656.268(3)(c), which requires that a worker be offered an actual modified job in writing, the plain language of ORS 656.325(5)(c) authorizes a carrier to pay TPD to a person present in the United States in violation of federal immigration laws when the attending physician approves employment in a modified job, *regardless of job availability*. ORS 656.325(5)(c) says nothing that expressly precludes payment of temporary disability because the injured worker is an illegal alien, nor does it state, unlike ORS 656.325(5)(b),[2] that the payment of temporary disability is contingent on a modified job that would have been offered to the worker had the worker remained employed.

In light of the omission of a contingency in ORS 656.325(5)(c), similar to that which is present in ORS 656.325(5)(b), we are mindful of the statutory enjoinder that we not insert into the statute what has been omitted, or omit what has been inserted. ORS 174.010; *PGE*, 317 Or at 611. Consequently, we conclude that the text and context of ORS 656.325(5)(c) unambiguously authorizes the carrier to stop paying TTD and to commence the payment of TPD when the physician approves employment in a modified job. That approval is the only precondition required by the legislature. The employer need not make a showing that a job would have been actually offered to the worker, or that it had a written policy of offering modified work to injured workers. Rather the record need only establish that a modified job for the employer has received approval from the claimant's attending physician that it is within the claimant's physical limitations.

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[1] ORS 656.268(3) provides in part:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker *returns* to * * * modified 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;* * * *." (Emphasis supplied.)

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

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

Applying our analysis to this case, we reach the following conclusion. When claimant's attending physician approved a modified job on November 21, 1997, SAIF was authorized to cease payments pursuant to ORS 656.210 (TTD) and commence payments pursuant to ORS 656.212 (TPD). *See Roberto Rocha-Barrancas*, 48 Van Natta 1462, 1463-64 (1996).

Rate Calculation

We next turn to the primary issue in dispute, *i.e.*, the actual calculation of claimant's TPD to which he is entitled under ORS 656.325(5)(c).[3] This first requires an analysis of the text and context of ORS 656.212, for the relationship between that statute and ORS 656.325(5)(c) lies at the heart of this dispute. ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character:
>
> "(1) No disability payment is recoverable for temporary disability during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.
>
> "(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that proportion of the payments provided for temporary total disability *which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210.*" (Emphasis added.)

Accordingly, when temporary disability becomes "partial," ORS 656.212(1) addresses the calculation of *when* the three-day waiting period for TPD payments begins. On the other hand, ORS 656.212(2) addresses the calculation of the actual amount of the TPD payments. Specifically, ORS 656.212(2) provides that TPD is calculated based on a comparison of a claimant's loss of wages, if any, at modified employment to the wage used to calculate TTD, *i.e.* claimant's at-injury wages. *See Lonnie L. Dysinger*, 47 Van Natta 2282, 2283 (1995).

In this case, claimant's disability became "partial" when Dr. Stringham approved modified work beginning on November 21, 1997. Claimant earned no wages after his release to modified work. Therefore, he had a complete loss of wages with which to compare to his at-injury wage. Thus, if one strictly applied ORS 656.212(2), claimant could conceivably be entitled to TPD at the full TTD rate, as the ALJ determined. But, in the case of an individual in the United States in violation of federal immigration law, ORS 656.325(5)(c) allows payment of TPD when the attending physician approves employment in a modified job "whether or not such a job is available."

Given its language, ORS 656.325(5)(c) allows payment of TPD at less than the full TTD rate to an illegal-alien claimant even if the claimant does not earn any wages, provided there is attending-physician approval of a modified job, regardless of the job's availability. Based on our examination of the relevant statutes, there is a seeming inconsistency between the statutory provisions in ORS 656.212(2), which would support payment of TPD at the full TTD rate, and ORS 656.325(5)(c), which would support payment of TPD at a lesser amount (even zero) if, as was true in this case, the attending physician approved modified work at a job that is nevertheless unavailable.

We are mindful, however, that, because ORS 656.325(5)(c) is a particular provision regarding payment of TPD to "illegal aliens," to the extent that there is any inconsistency between that provision and ORS 656.212, a general statutory provision, ORS 656.325(5)(c) is controlling. ORS 174.020; *PGE* 317 Or 611. In the context of the particular provision of ORS 656.325(5)(c) ("whether or not such a job is available"), we conclude that the calculation of TPD under ORS 656.212(2) does not require actual lost wages from modified employment in the case of an injured worker who is in this country in violation of federal immigration laws. Any other interpretation would render the particular provisions of ORS 656.325(5)(c) meaningless. *See* ORS 174.010; *PGE*, 317 Or at 611 (where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all).

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[3] The method of calculating TPD under ORS 656.325(5)(c) and OAR 436-060-0030(7) was not addressed in *Rocha-Barrancas*. 48 Van Natta at 1463 (Chair Hall specially concurring).

In other words, because an employer could not lawfully extend an offer of employment to a claimant who is present in this country in violation of federal immigration laws, that claimant could never receive wages for modified employment because a job offer would never be made. Thus, if we limited the reference to "loss of wages" in ORS 656.212(2) to *actual* wages attributable to a modified job, the authorization in ORS 656.325(5)(c) to commence paying TPD would effectively never reduce a claimant's TTD because an illegal alien would never return to modified employment and receive actual wages. An illegal alien would always receive "TPD" at the full TTD rate.

In light of the legislature's clear intent to reduce payments of temporary disability to persons present in the United States in violation of federal law from TTD to TPD, unlike the ALJ, we decline to broadly interpret ORS 656 212(2) as effectively requiring payment of TTD when an illegal alien is approved for modified work. Such an interpretation would undermine the very limitation the legislature sought to impose. Instead, we harmonize the provisions of ORS 656.325(5)(c) and 656.212, so as to give effect to both, and find that the wage for an "approved," but "non-offered," modified job must be included in the calculation of an illegal alien's TPD.

We now turn to the issue of whether OAR 436-060-0030(7) is consistent with our analysis of the statutory scheme. The ALJ concluded that this rule was an improper enlargement of the Department's statutory authority concerning its determination of temporary partial disability benefits. SAIF contends that the Director properly exercised his discretion in adopting OAR 436-050-0030(7) because the rule is consistent with the statutory provisions of ORS 656.325(5)(c) and ORS 656.212. We agree with SAIF for the following reasons.

ORS 656.726(3) charges the Director "with duties of administration, regulation and enforcement of [ORS Chapter 656]." In the discharge of his duties, ORS 656.726(3)(a) authorizes the Director to "[m]ake and declare all rules * * * which are reasonably required in the performance of the director's duties." *See Rager v. EBI Companies*, 107 Or App 22, 24 (1991); *Efrain C. Espinoza*, 45 Van Natta 348, 350-51 (1993). Therefore, the Director is expressly authorized under ORS 656.726(3) to determine the amount of TPD due under ORS 656.325(5)(c) and 656.212(2) to an injured worker and to prescribe the rules for making that determination. Thus, in a case such as this, in which an injured worker is in this country in violation of federal immigration laws, the Director has devised a method to calculate such a worker's rate of temporary disability. This is contained in OAR 436-060-0030(7), which provides:

> "Pursuant to ORS 656.325(5)(c), 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 whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:
>
> "(a) 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);
>
> "(b) The attending physician has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and
>
> "(c) The attending physician agrees the employment appears to be within the worker's capabilities." (Emphasis supplied.)

Here, the Department is charged with promulgating the rules by which TPD is calculated. Because TPD benefits are calculated under ORS 656.325(5)(c) whether or not the employer's modified job is "available," we find it reasonable for the Department to have promulgated a rule by which an approved modified job for the employer establishes a rate for an injured worker's "loss of wages" at modified work as required under ORS 656.212(2), "whether or not such a job is available," and "as if the worker had begun the employment." We, accordingly, find that OAR 436-060-0030(7) is reasonably required in the performance of the Director's duties. *Rager*, 107 Or App at 24. It is, therefore, valid and must be applied to this case.

To sum up, we conclude that ORS 656.325(5)(c) and 656.212 authorized SAIF to cease TTD payments and commence TPD payments when the attending physician approved a modified job for claimant with the employer. OAR 436-060-0030(7) provides a reasonable method, consistent with the

above statutes, by which the rate of TPD payments can be calculated *whether or not the modified job is available.*

Here, the parties agreed that claimant's average weekly wage at the time of injury was $270 and the employer's modified job that claimant's physician approved, whether or not it was available, was for the same hours and wages as the job at injury. If a claimant's wages at modified work are the same as his wages at the time of injury, the calculation of claimant's TPD equals zero. *See Audrey L. McDaniel*, 50 Van Natta 1423, 1424 (1998). Therefore, claimant's rate of TPD is zero.[4] ORS 656.212; OAR 436-060-0030(7).

Penalties

We concur with the ALJ's conclusion that SAIF's conduct was not unreasonable. In any event, because no payments of temporary disability were due after November 21, 1997 (because claimant's TPD rate was zero), there was no compensation "then due" on which to base a penalty. *See* ORS 656.262(11)(a).

ORDER

The ALJ's order dated April 20, 1998 is reversed in part and affirmed in part. Those portions of the order that awarded claimant temporary disability benefits for the period from November 21, 1997 to March 20, 1998, as well as an "out-of-compensation" attorney fee, are reversed. The remainder of the order is affirmed.

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[4] Because ORS 656.325(5)(c) provides for payment of TPD regardless of job availability, there is no need to distinguish between the period from November 21 to December 15, 1997, when claimant could have performed work for the employer, and the period subsequent to December 15, 1997, when the employer's modified job was no longer available because of the end of the Christmas tree harvest season.

Board Member Biehl dissenting.

I agree with the ALJ's ultimate conclusion that claimant is entitled to temporary partial disability under ORS 656.325(5)(c) regardless of job availability because he has suffered a "loss of wages" under ORS 656.212(2). In reaching this determination, I note that ORS 656.325(5)(c) does not state that an illegal alien is *not* entitled to temporary disability compensation. To the contrary, the statute expressly provides that the injured worker is entitled to temporary partial disability compensation *regardless of job availability*. Inasmuch as ORS 656.212(2) does not limit the "loss of wages" entitling a worker to temporary partial disability benefits to wages lost "as a result of the compensable injury," I concur with the ALJ's decision to award claimant such benefits in the amount calculated in her order. Consequently, I respectfully dissent.

In the Matter of the Compensation of
SHERRI L. WILLIAMS, Claimant
WCB Case No. 98-02639
ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our December 17, 1998 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside its denial of claimant's aggravation claim; and (2) set aside its denial of claimant's current low back condition. The employer contends that, by adopting the ALJ's opinion and order, we have not adequately explained the reasons for our determination. In addition, the employer asserts that claimant was not a credible witness and that the medical opinions based on the history she provided were not persuasive. Claimant has submitted a response, asserting that the Board's order is sufficient and appropriate.

As we have previously explained, by adopting and affirming an ALJ's order, we have found the order sufficient for appellate review. The facts and conclusions set forth in the ALJ's order also express the Board's opinion of the case. *See, e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997). In considering each case presented for review, the Board conducts a thorough and methodical review of the file and considers the parties' respective arguments on review. If we find the ALJ's order adequately states the facts, correctly applies the law and reaches the appropriate result under the facts presented in the record, we need not supplement the ALJ's order. *Id; see also* ORS 656.295(6) (Board may affirm, reverse, modify or supplement the ALJ's order and make such disposition of the case as it determines to be appropriate).

Although we consider the ALJ's order sufficient for appellate review, we will nevertheless address the employer's contentions on reconsideration. To begin, we briefly summarize the pertinent facts:

Claimant, a nurse in her mid-30s, compensably injured her low back on October 13, 1996. While standing in a doorway, she was bumped by a door that had blown closed. The door's metal bar struck her in the low back, causing a contusion. Claimant was seen in the hospital's emergency room and prescribed a muscle relaxant.

Claimant testified that she experienced low back pain after the incident, which improved a bit after a while but, by mid-1997, worsened and started radiating down into her hip. On October 31, 1997, she sought treatment with Dr. Greenleaf for her low back pain. Claimant advised Dr. Greenleaf that her pain had started about five days prior, after a long car ride.

In November 1997, claimant sought chiropractic treatment for her back pain. She was referred to Dr. Newby, who suspected a herniated disc and ordered an MRI. A December 26, 1997 MRI showed a small disc extrusion at L4-5.

Claimant began treating with Dr. Moore in early January 1998. Dr. Moore performed surgery on March 23, 1998, and claimant's symptoms improved.

Based on the assumption that claimant's low back symptoms did not persist until mid-to-late 1997, Dr. Greenleaf and Dr. Woodward (who evaluated claimant at the employer's request in March 1998) opined that claimant's disc herniation was probably not related to her October 1996 back injury. Dr. Moore, on the other hand, opined that if claimant had persistent mild pain following the October 1996 incident which gradually worsened and radiated into her buttock and leg, the major contributing cause of claimant's disc herniation would be the October 1996 incident. Dr. Moore agreed, however, that if claimant was essentially symptom free until the fall of 1997, her condition was probably not related to the October 1996 incident.

Finding that claimant had "testified credibly" at hearing as to her symptoms following the October 1996 incident and throughout 1997, the ALJ concluded that claimant had established a compensable aggravation of her low back injury. The ALJ relied on Dr. Moore's opinion that the October 1996 incident probably caused a tear in the annulus at L4-5, which later ruptured and resulted in claimant's worsening and radicular symptoms.

The employer asserts that claimant is not a credible witness or reliable historian and that she provided inconsistent accounts of her symptoms to her treating physicians.[1] The employer also argues that the medical opinions are insufficient to sustain claimant's burden. We find to the contrary.

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[1] On review, the employer asserted that claimant sought treatment for low back pain in June 1996, four months prior to the October 1996 incident. This assertion is not supported by the record. Although the record establishes that claimant obtained a prescription for Darvocet from Dr. Johnson on June 24, 1996, the doctor's chart note does not document claimant's complaint on that date. (Ex. 19). Rather, the *next* entry on the chart note, dated October 31, 1997 and initialed DLG, indicates that claimant complained of low back pain with radiation into the hips. *Id.*

As noted above, the ALJ specifically found that claimant "testified credibly" concerning her symptoms. As a general rule, the Board will generally defer to the ALJ's determination of credibility. *See Erck v. Brown Oldsmobile,* 311 Or 519, 526 (1991). Because the ALJ had the opportunity to observe the claimant's testimony, he is in a much better position to assess her credibility and his determination is entitled to considerable weight. *See, e.g., Bragger v. Oregon Trail Savings,* 275 Or 219, 221 (1976) (noting that a trial judge is in a much better position to assess the credibility of a witnesses than an appellate court and the judge's conclusion is entitled to considerable weight). Although inconsistencies in the record may be a sufficient basis to discount the ALJ's credibility determination, *see, e.g., David A. Peper,* 46 Van Natta 1656 (1994), we find nothing in the substance of claimant's or any other witnesses testimony in this case to cause us to doubt claimant's testimony regarding the progression of her low back symptoms. Consequently, we accept the ALJ's credibility determination.

Based on the understanding that claimant's low back symptoms began with the October 1996 injury and persisted and worsened until she sought treatment in the fall of 1997, Dr. Moore opined that the October 1996 injury was the major cause of claimant's disc injury. Neither Dr. Greenleaf nor Dr. Woodward challenged Dr. Moore's analysis or explanation concerning the development of claimant's condition; their contrary opinions were based on a different factual scenario (that claimant did not experience persistent symptoms between October 1996 and October 1997). After considering the medical evidence, we find no persuasive reason not to rely on Dr. Moore's opinion as to the cause of claimant's condition.

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

Accordingly, we withdraw our December 17, 1998 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our December 17, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

January 19, 1999 Cite as 51 Van Natta 77 (1999)

In the Matter of the Compensation of
ROBERT D. BAIR, Claimant
WCB Case No. 98-02342
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of claimant's current low back condition. On review, the issue is compensability.

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

On review, claimant argues that he has two low back conditions: a combined condition involving spondylolisthesis and degenerative disc disease and a low back strain. Claimant argues that the low back strain is separate from the combined condition and should be analyzed under the material contributing cause standard. We disagree.

The medical evidence is unrebutted that claimant's current low back condition is a combination of the injury and the preexisting condition. (Exs. 60-5; 62-1). Under such circumstances, the major contributing cause standard of ORS 656.005(7)(a)(B) applies to claimant's current low back condition.

ORDER

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

In the Matter of the Compensation of
ROBERTO BARO, Claimant
WCB Case No. 98-04413
ORDER ON REVIEW
Brothers & Ash, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its partial denial of claimant's injury claim for an L4-5 annular tear; and (2) awarded a $2,500 assessed attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

The next-to-last sentence in the second paragraph on page 4 is supplemented to read: "In contrast, Dr. Moore, claimant's most recent treating physician, opined that a fall off a 9 foot ladder, landing on the right side and back, could easily cause an L4-5 annular tear."

In addition, we offer the following supplementation regarding the attorney fee issue.

Claimant's attorney is entitled to a reasonable assessed fee for services provided at hearing in prevailing over SAIF's partial denial of claimant's L4-5 annular tear. 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 $2,500 for services at hearing in setting aside SAIF's partial denial, considering the factors in OAR 438-015-0010(4).

On review, SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award. SAIF does not argue that the $2,500 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 the ALJ was *required* by the rule to make findings of fact under *each* of the eight factors in OAR 438-015-0010(4); draw conclusions from those specific findings of fact; and demonstrate how those conclusions should be weighed in determining a reasonable attorney fee. We disagree with SAIF's arguments, as we have previously explained in *Daryl L. Underwood*, 50 Van Natta 2330 (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."

Here, the ALJ awarded a $2,500 attorney fee, having "considered the factors set forth in OAR 438-015-0010(4)." As in *Underwood*, the ALJ was 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.

Moreover, 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. The hearing lasted about 40 minutes. Claimant was the only witness who testified. The record consists of 38 exhibits, including a letter from claimant's counsel to Dr. Moore, claimant's current treating physician, and the doctor's response to counsel's inquiries. Dr. Moore's responses were favorable to claimant's position and pivotal to the outcome of the case.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average medical and legal complexity. The value of the interest and benefit secured were significant, considering the persistence of claimant's disc-related symptoms. Both attorneys presented their cases in a thorough 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 divided medical evidence.

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 $2,500, 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 might have gone uncompensated.

Claimant's attorney is entitled to an assessed fee for services related to the compensability issue 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 in this regard 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, claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 1, 1998 is affirmed. For services on review related to the compensability issue, claimant is awarded a $600 attorney fee, payable by the SAIF Corporation.

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

On October 26, 1998, we withdrew our September 24, 1998 Order on Review that affirmed an Administrative Law Judge's (ALJ'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. We took this action in response to the employer's announcement that the parties were in the midst of settlement negotiations and were requesting abatement of our decision.

We have since received a January 5, 1999 letter from claimant's counsel, which provides notice that "a settlement agreement was not reached between the parties." Consequently, claimant requests that we "move forward with this case by issuing an Order reinstating this case."

Inasmuch as the basis for our abatement order (the parties' settlement negotiations) no longer exists, we proceed with our reconsideration. On reconsideration, we 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.

In the Matter of the Compensation of
TODD A. HACKWORTH, Claimant
WCB Case No. 97-03611
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) admitted Exhibits 13, 14A, 16A, and 23 into evidence; and (2) upheld the insurer's denial of his injury claim for a left knee medial meniscus tear. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

During the course of litigation, claimant deposed a physician, Dr. Schilperoort, who examined claimant on behalf of the insurer. When queried about his qualifications, Dr. Schilperoort testified that he had retired on the basis of a medical disability. (Ex. 23-17). Claimant's attorney inquired as to the nature of the disability, but Dr. Schilperoort declined to answer, stating the reason for his retirement was not pertinent and was a personal matter. *Id.*

Claimant objected to the admission of the deposition, all of Dr. Schilperoort's reports and the concurrence letter of another physician (Dr. Korpa) who had agreed with one of Dr. Schilperoort's reports. Claimant argued that the reports should not be admitted because Dr. Schilperoort had refused to submit to cross-examination within the meaning of ORS 656.310(2) when he declined to explain the reason for his medical disability retirement.[1]

The ALJ overruled claimant's objection and admitted the disputed exhibits. The ALJ reasoned that Dr. Schilperoort had testified that his disability did not affect his ability to make medical judgments and diagnoses and that there had been no further follow-up addressing that answer.

On review, claimant renews his objection to the disputed medical evidence, once again contending that Dr. Schilperoort's refusal to answer the question regarding his medical disability retirement constitutes a failure to submit to cross-examination. For the following reasons, we decline to reverse the ALJ's evidentiary ruling.

ALJs are not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7). The ALJ has broad discretion in determinations concerning the admissibility of evidence. *See e.g. Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *See Thomas E. Andrews*, 47 Van Natta 2247 (1995).

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[1] ORS 656.310(2) provides in part:

"The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination."

Here, Dr. Schilperoort did submit to cross-examination, during which he answered all questions pertaining to his medical reports. While Dr. Schilperoort refused to answer one question regarding the nature of his medical disability, Dr. Schilperoort also testified that his disability was not of a kind that would affect his ability to make medical diagnoses or medical judgments. (Ex. 23-18). Although claimant had the opportunity to inquire further about this testimony, he did not do so. Moreover, we accept Dr. Schilperoort's testimony, given under oath, that his disability would not affect his ability to evaluate this case. Accordingly, we conclude that the ALJ did not abuse his discretion in making his evidentiary ruling.

On the merits, claimant contends that the ALJ should have found that he sustained his burden of proving a material causal relationship between his compensable 1993 left knee injury, accepted as a nondisabling left knee strain, and his current left knee condition, diagnosed in 1997 by Dr. Webb as a torn left medial meniscus. We disagree.

On August 9, 1993, Dr. Korpa, claimant's attending physician, declared claimant medically stationary without permanent impairment with respect to the original compensable injury. Diagnosing a left knee strain, Dr. Korpa noted that claimant demonstrated excellent range of motion, had no effusion or focal tenderness, walked without a limp, and had intact cruciate and collateral ligaments. (Ex. 3-2). Claimant did not seek treatment again until August 1, 1994, when he consulted Dr. Wenner for left knee pain. (Ex. 6). Dr. Wenner diagnosed pes anserine inflammation, for which anti-inflammatories were prescribed. Dr. Wenner specifically noted that there was no evidence of a meniscus tear. Claimant did not seek medical treatment until March 1997, when he again sought treatment from Dr. Korpa, who eventually referred claimant to Dr. Webb.

Dr. Webb opined that claimant's meniscus tear was related to the original compensable injury (Ex. 17), while Dr. Schilperoort reached an opposite conclusion. (Ex. 23). Although claimant argues that Dr. Webb's opinion is more persuasive than Dr. Schilperoort's, we find support for the latter physician's opinion in the recent reports of Drs. Wenner and Korpa.

Dr. Wenner opined on February 3, 1998 that claimant did not have a meniscal tear in 1994. (Ex. 19). Dr. Wenner acknowledged, however, that he could not say with "absolute certainty" that claimant did not have a meniscus tear in 1994. We emphasize that medical certainty is not required. *Robinson v. SAIF*, 147 Or App 157, 160 (1997); *Douglas G. Abbott*, 50 Van Natta 1156, 1158 1998). We are persuaded that Dr. Wenner's medical report establishes to a degree of "medical probability" that claimant did not have a meniscus tear in 1994 and, thus, that the tear must have occurred subsequent to that time. Dr. Korpa's most recent report on February 12, 1998 also supports that conclusion. (Ex. 22). Dr. Korpa agreed that he found no indication that claimant had a meniscus tear in July and August 1993 and that the appropriate diagnosis at that time was a left knee strain.

Accordingly, based on the medical evidence from Drs. Schilperoort, Wenner and Korpa, we conclude that claimant failed to sustain his burden of proving a material causal connection between his original compensable injury and his current left knee condition.[2] Therefore, we affirm.

ORDER

The ALJ's order dated July 27, 1998 is affirmed.

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[2] Alternatively, even if we did not consider the disputed medical evidence from Dr. Schilperoort (including Dr. Korpa's concurrence), we would still conclude, based on the remaining medical evidence, that claimant failed to sustain his burden of proof.

In the Matter of the Compensation of
RANDOLPH KING, Claimant
WCB Case No. 98-03799
ORDER WITHDRAWING ORDER OF DISMISSAL
Steven M. Schoenfeld, Claimant Attorney
Reinisch, et al, Defense Attorneys

On December 11, 1998, we abated our November 12, 1998 order that dismissed claimant's request for review. We took this action to consider claimant's motion for reconsideration. The self-insured employer also responded to claimant's motion and asserted that we should affirm our order. We now proceed with our reconsideration.

As we explained in our prior order, Administrative Law Judge (ALJ) Herman issued an Opinion and Order on September 8, 1998. We found that 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. Also included was an October 2, 1998 letter from the employer's counsel acknowledging receipt of a copy of the request for review.

We decided that, although the September 16, 1998 letter was dated within 30 days of the ALJ's September 8, 1998 order, the record failed to show that the Board received the request prior to expiration of the 30-day appeal period. Consequently, we concluded that claimant did not timely filed his request for review and we lacked jurisdiction to review the ALJ's order.

In requesting reconsideration, claimant includes an affidavit from his counsel's legal assistant attesting that the legal assistant, on September 16, 1998, mailed the original request for review to the Board and, on the same date, sent copies of the request to claimant and the employer's attorney. Claimant contends that the affidavit, along with evidence showing that the employer's attorney received a copy of the request before the 30-day period, is enough to rebut the presumption that claimant untimely filed the request for review.[1]

The employer objects to claimant's request for reconsideration, arguing that, because claimant did not provide "*independent* corroborative evidence of timely filing," he failed to rebut the presumption. According to the employer, the "Board's rule is reduced to a nullity if all one must do to rebut [the presumption] is to assert [the request] was timely mailed in a staff affidavit."

Under OAR 438-005-0046(1)(b), if filing of a request for review is through the mail, "it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail[.]" If the Board actually receives the request after the date of filing, "it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely."

Here, claimant did not mail the request for review by registered or certified mail and the Board actually received the request for review after expiration of the 30-day appeal period. Thus, in order to rebut the presumption, claimant must establish that the mailing was timely.

We agree with claimant that he rebutted the presumption. Claimant's attorney's legal assistant attested to mailing the request for review to the Board, and copies to claimant and the employer's counsel, on September 16, 1998, well before the 30-day appeal period ended on October 8, 1998. This information is corroborated to some extent by the undisputed fact that the employer's counsel had received its copy as of October 2, 1998. Thus, we conclude that claimant established that mailing of the request for review was timely. *See Brian L. Schmitt*, 48 Van Natta 295 (1996) (the claimant rebutted the presumption under OAR 438-005-0046(1)(b) by showing that the carrier received a copy of the request before expiration of the appeal period and evidence showing the claimant's counsel's customary procedure of mailing the request to the Board, and a copy to opposing counsel, on the same date).

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[1] Claimant also relies on information in the affidavit that the legal assistant spoke to a Board employee and the employee stated that the Board probably had lost the original request for review. We find this portion of the affidavit has little relevance to the question of whether claimant rebutted the presumption of untimely filing, and we do not base our decision on it.

Accordingly, on reconsideration, we withdraw our November 12, 1998 order. A hearing transcript has been ordered. On its receipt, copies will be distributed to the parties along with a briefing schedule. Following completion of the briefing schedule, we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELANIE K. MASON, Claimant
WCB Case No. 98-03291
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Richard C. Pearce, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) declined to award an assessed attorney fee; and (2) declined to award a penalty or penalty-related attorney fee. On review, the issues are attorney fees 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 has an accepted claim with the SAIF Corporation as a result of an injury sustained when claimant worked for Jim Fisher Nissan. In February 1998, claimant filed an injury claim with Beaverton Nissan, claimant's subsequent employer; Universal Underwriters Insurance Company is Beaverton Nissan's insurer and the only carrier involved in this proceeding. About the same time, claimant also filed an aggravation claim with SAIF.

Universal Underwriters initially denied compensability and responsibility, and then withdrew the compensability denial. SAIF denied the aggravation claim, then entered into a Claim Disposition Agreement (CDA), in which claimant released her rights to certain benefits in exchange for a sum of money. The agreement also provided an attorney fee to claimant's counsel.

Claimant proceeded to hearing, alleging that she was entitled to an assessed attorney fee for Universal Underwriter's withdrawal of its compensability denial. Claimant also asserted that she was entitled to a penalty because Universal Underwriter's compensability denial was unreasonable.

Attorney Fees

The ALJ decided that claimant was not entitled to an assessed attorney fee under ORS 656.386(1). In particular, the ALJ found that, had the compensability/responsibility issue proceeded to hearing, the ALJ would have found SAIF responsible. Thus, the ALJ reasoned that SAIF also was liable for the entire attorney fee. Claimant challenges this conclusion, asserting that, under the terms of the statute, she is entitled to an assessed attorney fee whether or not she entered into a CDA with SAIF.

ORS 656.386(1)(a) in relevant part 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." Based on such language, we have held that a nonresponsible carrier is liable for an attorney fee award for rescinding a compensability denial. *Elizabeth H. Nutter*, 49 Van Natta 829 (1997).

In *Nutter*, two carriers denied compensability and then, before hearing, conceded compensability. They proceeded to hearing to decide responsibility. On review, the Board awarded an attorney fee under ORS 656.386(1), payable by the nonresponsible carrier, after finding that the nonresponsible carrier rescinded a denial of compensability and the claimant's attorney had been instrumental in obtaining the rescission. In a footnote, the Board distinguished the case from those where only the responsible carrier was liable for the assessed attorney fee, explaining that, because the compensability denial had not been rescinded before hearing, those cases came under that portion of the statute allowing a fee only when the claimant "finally prevails" over a denial. 49 Van Natta at 830.

We find this case governed by *Nutter*. That is, if Universal Underwriters rescinded its denial and claimant's attorney was instrumental in obtaining that rescission, claimant is entitled to an assessed attorney fee under ORS 656.386(1).

We first find that, because Universal Underwriters withdrew its compensability denial, it rescinded the denial before hearing. Furthermore, because claimant filed a request for hearing before the rescission and prepared a case to prove compensability, we conclude that claimant's attorney was instrumental in obtaining the rescission. *Id.* at 831.

Finally, claimant argues that she is entitled to a second assessed attorney fee because, at hearing, Universal Underwriters "again denied compensability." Whether or not Universal Underwriters reasserted a denial of compensability at hearing, we find no statutory basis for awarding a second attorney fee. The ALJ did not address compensability and the parties do not raise that issue on review. Thus, claimant did not "finally prevail" against a denial. Moreover, there is no contention that Universal Underwriters rescinded its "reasserted" compensability denial before hearing.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services in obtaining a pre-hearing rescission of Universal Underwriters' denial is $750, payable by Universal Underwriters. 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 counsel may go uncompensated. Claimant's counsel is not entitled to an attorney fee for services rendered subsequent to the rescission of the compensability denial. *See Amador Mendez*, 44 Van Natta 736 (1992).

Penalties

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

ORDER

The ALJ's order dated August 31, 1998 is reversed in part and affirmed in part. That portion of the order declining to award an assessed attorney fee is reversed. Claimant's attorney is awarded an assessed fee of $750, to be paid by Universal Underwriters. The remainder of the order is affirmed.

In the Matter of the Compensation of
GEORGINA F. LUBY, Claimant
WCB Case No. 98-03238
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration award of 15 percent (22.5 degrees) scheduled permanent partial disability (PPD) for loss of use or function of the right knee. Claimant moves to strike the employer's "cross-reply" brief, and the employer moves to strike claimant's appellant's brief. On review, the issues are the motions to strike and scheduled PPD. We deny the motion to strike claimant's appellant's brief, grant the motion to strike the employer's "cross-reply" brief, and affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the following additional findings.

At his closing examination on October 6, 1997, Dr. Brenneke noted +1 effusion of the right knee, and the possible need for further episodic treatment of this inflammatory component. (Ex. 11).

When the medical arbiter examined claimant on March 21, 1998, he found "no palpable effusion at this time," and slight increased valgus on the right knee of 8 to 9 degrees, compared to 7 degrees on the left. (Ex. 17-3).

Motions to Strike

The employer moves to strike claimant's appellant's brief "if the Board concludes that the brief is untimely." The employer asserts that an October 15, 1998 briefing notice from the Board states that the appellant's brief was due on October 16, 1998. At the same time, the employer acknowledges that an earlier October 9, 1998 briefing notice identifies October 19, 1998 as the due date for the appellant's brief. Claimant's appellant's brief was mailed on October 19, 1998.[1]

We deny the employer's motion to strike claimant's appellant's brief. Even assuming that the alleged October 15, 1998 briefing notice was sent, we would conclude that claimant's brief was timely because it was mailed on the due date identified in the October 9, 1998 briefing notice.

We turn to claimant's motion to strike the employer's "cross-reply" brief. Pursuant to OAR 438-011-0020(2), only a cross-appellant may file a cross-reply brief. Here, the employer cannot be a cross-appellant because it did not cross-request Board review of the ALJ's order. Accordingly, we grant claimant's motion to strike the employer's "cross-reply" brief.

Scheduled PPD

Claimant contends that the ALJ erred in not awarding an additional 5 percent impairment value for chondromalacia under OAR 436-035-0230(13).[2] This provision provides as follows:

> "A value of 5% of the leg shall be granted if there is a diagnosis of Grade IV chondromalacia, extensive arthritis or extensive degenerative joint disease and one or more of the following:
>
> "(a) Secondary strength loss;
>
> "(b) Chronic effusion;
>
> "(c) Varus or valgus deformity less than that specified in section (4) of this rule."

Section 4 of this rule provides for an impairment value where the compensable injury results in varus or valgus deformity of the knee greater than 20 degrees.

The ALJ concluded that claimant was not entitled to an impairment value under OAR 436-035-0230(13) because "[n]either the medical arbiter nor any other physician in the record * * * have indicated that claimant also exhibits secondary strength loss, chronic effusion, or varus or valgus deformity in the right knee." On review, claimant asserts that the record establishes the additional chronic effusion and/or valgus deformity required under the rule.

Claimant relies on Dr. Brenneke's operative finding of a small area of Grade IV chondromalacia in the lateral femoral condyle, and his closing examination finding of +1 effusion with possible further episodic treatment for this inflammatory component. Claimant also relies on the arbiter's diagnosis of a small area of chondromalacia of the lateral femoral condyle, and his finding of slight increased valgus on the right knee of 8 to 9 degrees, compared to 7 degrees on the left.[3]

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[1] To be timely filed, an appellate brief must be mailed or physically delivered to any permanently staffed office of the Board on or before the due date. *See* OAR 438-005-0046(1)(c).

[2] Pursuant to OAR 436-035-0003(2), the standards for rating disability in effect on the date of the October 27, 1997 Notice of Closure apply to claimant's claim. (WCD Admin. Order 96-072).

[3] Where a medical arbiter is used, impairment is determined by the arbiter except where a preponderance of medical opinion, from the attending physician or other physicians with whom the attending physician concurs, establishes a different level of impairment. ORS 656.245(2)(b)(B) and 656.268(7); OAR 436-035-0007(13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

We are not persuaded that Dr. Brenneke's closing examination finding of +1 effusion establishes the *chronic* effusion required under OAR 436-035-0230(13). Claimant exhibited no palpable effusion four months later when she was examined by the arbiter. *See* ORS 656.283(7) (impairment is rated as of the date of the reconsideration order). Furthermore, Dr. Brenneke's identification of a *possible* need for further episodic treatment of the effusion does not satisfy claimant's burden of establishing a chronic condition by a preponderance of the evidence. ORS 656.266 and 656.283(7).

Furthermore, we are not persuaded that claimant is entitled to an impairment value based on the medical arbiter's finding of a valgus deformity. Dr. Brenneke and the arbiter diagnosed diffuse Grade III chondromalacia in the retropatellar area, as well as a small area of Grade IV chondromalacia in the lateral femoral condyle.[4] Although the arbiter expressly attributed the patellar chondromalacia to the compensable injury, he offered no express opinion as to the causation of the lateral femoral condyle chondromalacia. As the Grade III chondromalacia is not ratable, the arbiter's valgus finding cannot be considered unless it is related to the separate Grade IV chondromalacia. Therefore, on the record before us, assuming the Grade IV chondromalacia to be compensable, we cannot ascertain whether the valgus finding is related to the small area of Grade IV chondromalacia or the more diffuse Grade III chondromalacia.

In summary, we conclude that the opinions of Dr. Brenneke and the arbiter do not establish claimant's entitlement to an additional impairment value for chondromalacia under OAR 436-035-0230(13).[5] For this reason, we conclude that the ALJ acted correctly in affirming the reconsideration award of 15 percent scheduled PPD.

ORDER

The ALJ's order dated August 20, 1998 is affirmed.

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[4] We reject the employer's alternative contention that claimant's chondromalacia is not ratable under the standards because the arbiter's diagnosis did not classify the chondromalacia in the lateral femoral condyle as Grade IV. The arbiter noted elsewhere in his report that, at the time of the July 10, 1997 surgery, "the chondromalacia of the patella had increased to a Grade III [and] there was also an area of Grade IV, small, on the lateral femoral condyle, about 5 mm in area." This notation is consistent with Dr. Brenneke's surgical finding of a small area of Grade IV chondromalacia in the lateral femoral condyle.

[5] The employer also challenges the ALJ's findings insofar as they suggest that claimant's Grade III chondromalacia is a compensable condition. As Grade III chondromalacia is not ratable under OAR 436-035-0230(13), we decline to address the etiology of this condition.

In the Matter of the Compensation of
SHELDON S. MERYS, Claimant
WCB Case No. 98-02457
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's occupational disease claim for a respiratory condition; and (2) awarded claimant's counsel an assessed fee of $4,000 for services at hearing. On review, the issues are compensability and attorney fees.

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

Citing *Schoch v. Leupold & Stevens*, 325 Or 112 (1997), SAIF argues that the ALJ erred by not specifically addressing the factors in OAR 438-015-0010(4). SAIF indicates that it is not contending "at this point" that the ALJ's award of a $4,000 attorney fee is excessive. Instead, SAIF argues that there is insufficient information from which to determine if the fee is excessive.

We have previously rejected SAIF's argument regarding the applicability of the *Schoch* case. *See Russell L. Martin*, 50 Van Natta 313 (1998) (ALJ 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 any argument to the ALJ as to how the rule-based factors should be weighed in determining a reasonable fee); *see also Daryl L. Underwood*, 50 Van Natta 2330 (1998) (in the absence of a specific attorney fee request or any argument as to how the rule-based factors should be weighed in determining a reasonable fee, it is sufficient for the ALJ to describe the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded).

Here, because the ALJ indicated that she applied the rule-based factors in determining the fee, there was no specific attorney fee request, and SAIF does not raise any arguments concerning how the rule-based factors should be applied, the ALJ's order is sufficient for review. Nonetheless, in addition to the ALJ's discussion, we provide the following reasoning.

The hearing lasted approximately 3 hours. Four witnesses testified and the transcript is 76 pages in length. The issue was medically complex because it involved the compensability of a respiratory condition alleged to be caused by exposure to UV coating materials at work. At least three exhibits were generated by claimant's attorney. The value of the interest and the benefit secured were not insubstantial because claimant lost time from work due to the condition and required medical treatment. Thus, at a minimum, claimant will likely receive compensation for medical services and possibly temporary disability. Both attorneys tried the case in a skillful manner. Because the medical evidence regarding compensability was divided, there was a significant risk that claimant's attorney might go uncompensated. After our review of these factors, we agree with the ALJ that a fee of $4,000 is reasonable.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 20, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
JOSEPH H. RETTINGER, Claimant
WCB Case No. 98-02982
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) Crumme's order that: (1) found that claimant's occupational disease claim was timely filed; (2) set aside the insurer's denial of claimant's occupational disease claim for left plantar fasciitis; and (3) assessed a penalty for the insurer's allegedly unreasonable denial. On review, the issues are timeliness, and if timely, 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 finding of fact 15.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim and Compensability

We adopt the ALJ's conclusions and reasoning regarding these issues.

Penalties

The ALJ assessed a penalty pursuant to ORS 656.262(11)(a). The ALJ found that the denial of compensability on the merits was unreasonable because when it was issued the only medical report in existence was that of Dr. Neumann which was ambiguous regarding compensability. The ALJ reasoned that the insurer prejudged the medical evidence regarding causation and denial the claim without a legitimate doubt. The ALJ also found that the amended denial that asserted that the claim was filed too late was also unreasonable. The ALJ concluded that, in order to deny the claim on the basis of timeliness, the insurer needed to know when claimant was first told by a physician that his claim was probably work-related. *See* ORS 656.807(1)(a), (b).[1]

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).

At the time it issued its denial, the insurer had the report of Dr. Neumann. That report did not indicate that the work activities were the *major* contributing cause of claimant's occupational disease claim. Thus, at the time of the denial, the medical evidence did not satisfy the compensability standard for claimant's occupational disease claim. Under such circumstances, we find that the insurer had a legitimate doubt regarding its liability for the condition.

In addition, we find that the insurer had a legitimate doubt as to its liability when it issued its "timeliness" denial. In this regard, the information available to the insurer at the time of its denial was that the claim was filed more than one year after claimant initially experienced disability due to the left plantar fasciitis condition. This information suggested that the claim was probably untimely under ORS 656.807. Based on this record, we find that no penalty is warranted.

Claimant's attorney is entitled to an assessed fee for services on review regarding the timeliness and compensability 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 regarding the timeliness and compensability issues is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated August 10, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

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[1] ORS 656.807(1)(a) - (b) provides: "(1) 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."

In the Matter of the Compensation of
MICHAEL D. ROLLINS, Claimant
WCB Case Nos. 97-08764 & 97-04653
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed By Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside the self-insured employer's denials of claimant's low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a lumbar strain. The employer issued denials for degenerative conditions at L4-5 and L5-S1. The ALJ upheld the denials after finding that the medical opinions supporting compensability were not persuasive. Claimant challenges this conclusion, asserting that, because his treating physicians support causation, those opinions are entitled to deference.

The record contains numerous opinions concerning claimant's current low back condition. Claimant's treating osteopath, Dr. Gray, reported that claimant "has degenerative disk disease and degenerative arthritis" that were, "in major part, caused by his work * * * over the years." (Ex. 30). Dr. Gray added that "the primary cause of his on-going symptoms are related to his industrial work[.]" (*Id.*)

Examining physicians, Dr. Stanford, orthopedic surgeon, and Dr. Farris, neurologist, found that claimant "has a chronic condition in his lumbar spine" that was unrelated to the lumbosacral strain. (Ex. 32-6). The panel further noted that claimant was "deconditioned and exhibits pain behavior with many inconsistencies today." (*Id.*) The panel also reported claimant also had "degenerative changes" and that condition was "the major contribution cause for his low back pain and impairment," finding it "very hard to attribute this much pain and alleged impairment to a simple back strain[.]" (*Id.* at 7).

Dr. Gray then indicated that he did not concur with the Stanford/Farris report. (Ex. 33). In particular, Dr. Gray reported that claimant's "lumbar strain has resolved" and that "ongoing degenerative problems are the cause of his continued symptoms." (*Id.*)

Dr. Tiley, orthopedic surgeon, also examined claimant on behalf of the employer. He also found that the back strain was resolved and that symptoms were "related to a pre-existing problem, namely degenerative spondylosis of his low back." (Ex. 39-6). According to Dr. Tiley, claimant's "general work activities have not contributed to his underlying disease on a more likely than not basis" because "work activities have been fairly moderate over the years." (*Id.* at 6-7).

Dr. Stanford and Dr. Farris concurred with Dr. Tiley's report. (Exs. 42, 46).

Dr. Thomas, orthopedic surgeon, performed an "arbitration examination" for the Department and diagnosed lumbosacral strain, degenerative arthritic changes with disc bulging at L5-S1, and exogenous obesity and physical deconditioning. (Ex. 47-2). According to Dr. Thomas, only the first diagnosis (lumbosacral strain) was related to the industrial injury. (*Id.*)

Dr. Noyes also treated claimant; he indicated that the major contributing cause of claimant's degenerative disc disease was work activities. (Ex. 48-1). Dr. Noyes also indicated that the industrial injury "aggravated or worsened" claimant's preexisting degenerative condition. (*Id.* at 2).

Dr. Berkeley, neurosurgeon, examined claimant at claimant's request. According to Dr. Berkeley, although claimant had a preexisting condition, because claimant did not have symptoms until the industrial injury, "the sole and main precipitating factor in causing symptoms" was the industrial injury. (Ex. 51).

Dr. Farris and Dr. Thomas, orthopedic surgeon, performed another examination on behalf of the employer. Their report found that claimant's "primary condition * * * is a somatic preoccupation with significant functional overlay." (Ex. 52-7). Although the panel acknowledged the preexisting degenerative condition, it thought that such condition only "may be responsible for some minor aches and pains and minor stiffness in these regions." (*Id.*) With regard to the industrial injury, the panel found it "insignificant as far as its contribution to his present condition" because that injury had "resolved." (*Id.* at 7-8).

Absent persuasive reasons to the contrary, we generally defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810 (1986). Here, Dr. Gray and Dr. Noyes, who both treated claimant, attributed claimant's preexisting degenerative condition to work activities. We find persuasive reasons not to defer to those opinions.

First, neither physician provides sufficient reasoning for their conclusions. We find such absence more significant in light of Dr. Tiley's opinion that claimant's work activities were moderate and not the type to cause a degenerative condition. Furthermore, as Dr. Noyes stated, a degenerative condition is also the result of aging and neither physician explained why work was a greater factor than aging.

Moreover, as Dr. Thomas and the Stanford/Farris and Farris/Thompson panels noted, other factors, including obesity, deconditioning, and pain behavior, also contributed to claimant's condition. Neither Dr. Gray nor Dr. Noyes discussed these factors or explained why work activities nevertheless were the major contributing cause.

For these reasons, we do not defer to the opinions of Dr. Gray and Dr. Noyes. The remaining opinion from Dr. Berkeley indicates only that the industrial injury was the precipitating cause of claimant's symptoms. Such an opinion is not sufficient to show that the compensable injury is the major contributing cause of the need for treatment and disability of a "combined condition." *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).

Thus, at best, we find the medical opinions to be in equipoise. Consequently, claimant failed to prove compensability of his degenerative low back condition. *See* ORS 656.005(7)(a)(B), 656.802(2)(b).

ORDER

The ALJ's order dated September 3, 1998 is affirmed.

In the Matter of the Compensation of
WALLACE W. WACKER, Claimant
WCB Case Nos. 98-02624 & 98-00475
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's occupational disease claim for a thoracic disc syndrome condition. On review, the issue is compensability.

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

We find no evidence that a spinal condition preexisted claimant's 37-year work exposure. Consequently, claimant need only prove that his repetitive traumatic work activities were the major contributing cause of the claimed thoracic disc syndrome condition, under ORS 656.802(2)(a). *See New Portland Meadows v. Dieringer*, 153 Or App 383, 387 (1998).

We agree with the ALJ that the opinion of Dr. Karasek, treating physician, persuasively establishes that claimant's work activities (particularly jitney driving, with jarring and vibration of a rotated torso) were the major contributing cause of his thoracic disc syndrome condition.

We acknowledge that Dr. Karasek at one point stated that work was not the major cause of claimant's condition (only of his need for treatment).[1] (Ex. 50-2). But Dr. Karasek subsequently explained that, while work did not cause the "underlying degenerative condition," it did cause the "painful thoracic syndrome." (Ex. 51). In our view, the latter comments clarify the former: The "condition" in the first refers to degeneration, as distinguished from the "thoracic disc syndrome," in the second and other opinions. (*See* Exs. 26, 37, 43, 47, 50, 51; *see also* Exs. 20A, 22, 27, 34, 42-2). Claimant's thoracic disc syndrome is the diagnosed *current* condition; it results from work activities superimposed on degeneration. Dr. Karasek's opinion as a whole indicates that claimant's repetitive traumatic work activities contributed more to his thoracic disc syndrome condition than did other causes, including the underlying degenerative condition.

In addition, although Dr. Karasek reasoned that work was the major cause of the syndrome condition because it "precipitated" claimant's need for treatment, we find that Dr. Karasek's opinion was not based solely on a "precipitating cause" analysis. In this regard, we note that the doctor evaluated and relied on the specific mechanism of injury wrought by claimant's work--vibration, jarring, and torsional trauma. This reasoning is effectively unrebutted, because the contrary opinions do not address or rule out vibration and jarring as contributing causes. Under these circumstances, we agree with the ALJ that there is no reason to discount Dr. Karasek's opinion. We rely on it because it is well reasoned and based on an accurate and complete history.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 13, 1998 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the insurer.

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[1] The insurer is correct that *SAIF v. Nehl*, 148 Or App 101 (1997), is not supportive of this *occupational disease* claim. *See Willard A. Hirsch*, 49 Van Natta 1311, n.1 (1997).

In the Matter of the Compensation of
THOMAS G. DOBSON, Claimant
WCB Case No. 97-09982
ORDER OF ABATEMENT
Donald M. Hooton, Claimant Attorney
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of those portions of our December 22, 1998 Order on Review that: (1) determined that his claim should not be reclassified as disabling; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claims processing. On reconsideration, claimant submits an October 8, 1998 report from Dr. Buuck, which claimant contends was not available at the time of hearing. Claimant requests remand to the Administrative Law Judge (ALJ) for purposes of reopening the record and considering the new exhibit. Alternatively, claimant argues that our conclusion that his claim should not be reclassified as disabling is not supported by the evidence.

In order to consider this matter, we withdraw our December 22, 1998 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD A. WESTLAKE, Claimant
WCB Case No. 98-00033
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that: (1) found that the insurer's acceptance of claimant's left shoulder impingement syndrome did not encompass his preexisting degenerative arthritis or changes at the AC joint and on his distal clavicle; (2) upheld the insurer's denial of the AC degenerative and distal clavicle conditions; and (3) declined to assess a penalty for an allegedly unreasonable denial. The insurer has also moved to strike claimant's reply brief as untimely. On review, the issues are motion to strike, claim processing, compensability and penalties.

We deny the motion to strike and adopt and affirm the ALJ's order with the following supplementation.

Motion to Strike

The insurer moves to strike claimant's brief on the ground that it was untimely filed. For the following reasons, we deny the motion.

The insurer filed its respondent's brief on October 14, 1998. Thus, claimant's reply brief was originally due on October 28, 1998. Thereafter, in response to claimant's timely filed extension request, we granted an extension of time in which to file the reply brief to November 17, 1998. Claimant's brief was timely filed on that date in accordance with the amended briefing schedule. The insurer, however, moves to strike the reply brief, arguing that claimant never intended to request an extension of time in this case. In response, claimant notes that his reply was timely filed in accordance with the amended briefing schedule. Under these circumstances, we find that the reply brief was timely filed and, thus, deny the motion to strike.

Claim Processing

The insurer accepted an injury claim resulting from a March 25, 1996 incident in which claimant fractured and dislocated his ankle. After initially accepting a "fracture dislocation of left ankle," the insurer accepted an acute impingement syndrome of the left shoulder. (Ex. 15). On November 29, 1996, Dr. Jacobson performed right shoulder surgery, in which the subacromial impingement was decompressed by removal of about seven millimeters of the anterior acromion. Dr. Jacobson also repaired the rotator cuff tear and resected the AC joint. (Ex. 23).

On September 17, 1997, an Order on Reconsideration awarded an impairment value for the distal clavicle resection. The insurer then denied claimant's preexisting degenerative arthritis or "changes" at the AC joint and the inferior spur on claimant's distal clavicle. (Ex. 28). Claimant requested a hearing.

The ALJ rejected claimant's argument that the denial was an impermissible "back-up" denial. The ALJ reasoned that, because claimant's accepted right ankle and left shoulder condition were unaffected by the insurer's denial, that denial did not deny the original injury claim.

On review, claimant argues that the insurer's acceptance of "acute impingement syndrome" encompassed the conditions that it later denied. Claimant asserts that the insurer's acceptance should include all factors that contribute to the impingement syndrome. Because the denied degenerative conditions at the AC joint and the spur on the distal clavicle contributed to the impingement syndrome, claimant argues that the insurer's acceptance encompassed those conditions and, thus, were the subject of a "back-up" denial. We disagree.

Dr. Jacobson's testimony establishes that the impingement condition and the preexisting degenerative changes are separate processes having different etiologies. Claimant's arthrosis (bone spurs) is a degenerative condition not caused or worsened by the compensable March 1996 injury. (Ex. 30-24, 25). On the other hand, the impingement syndrome has a traumatic origin and involves rotator cuff pathology. (Ex. 30-22). Based on the medical and lay evidence in this record, we are not persuaded that the denied degenerative conditions in claimant's shoulder are within the scope of the accepted acute impingement syndrome.

Claimant also argues that, while the insurer denied "preexisting" degenerative arthritis of the AC joint, claimant did not have preexisting "arthritis," but rather preexisting "arthrosis." Citing Dr. Jacobson's testimony that "arthritis" is the degenerative condition after it is rendered symptomatic by injury, claimant contends that the denied arthritis condition could not have preexisted the compensable injury because it did not come into existence until the compensable injury. Therefore, claimant argues that the insurer's denial should be set aside because it denied a condition that did not exist.

Claimant's argument is not persuasive. The insurer's denial states that preexisting degenerative arthritis or "changes" at the AC joint and the inferior spur on claimant's distal clavicle were denied. Based on the language of the denial, we find that it adequately described the denied condition. Moreover, claimant did not object to the insurer's denial on this basis at the hearing. (Tr. 2). Therefore, we decline to set aside the denial on the asserted ground.[1]

Compensability

In *Linda K. Holcomb*, 49 Van Natta 1491 (1997), the claimant's temporary disability was caused by both her compensable condition and a noncompensable lung lesion and thoracotomy. We held that ORS 656.225 provided no authority for disallowing the claimant's temporary disability. Claimant argues that her degenerative conditions are compensable under *Holcomb*. We disagree.

Unlike *Holcomb*, there is no dispute regarding entitlement to temporary disability in this case. Thus, we find *Holcomb* inapposite on this basis. Moreover, while it was necessary in this case to treat the noncompensable degenerative conditions in order to alleviate the compensable impingement syndrome, this does not make the noncompensable degenerative conditions compensable in and of themselves. In order for them to be compensable, the compensable injury must be the major contributing cause of the need for medical treatment of the "combined condition" consisting of the compensable injury and the preexisting and noncompensable degenerative conditions. *See* ORS 656.005(7)(a)(B). We agree with the ALJ that the medical evidence does not establish this. Thus, we continue to find that the ALJ properly upheld the insurer's denial.

Penalties

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

ORDER

The ALJ's order dated July 16, 1998 is affirmed.

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[1] Claimant argues that a decision to affirm the ALJ's holding on the "back-up" denial issue would amount to a requirement that each anatomical part be specifically accepted, thus encouraging excessive litigation. Claimant's policy argument notwithstanding, our decision is limited to the particular facts of this case and, thus, does not constitute a ruling on future cases. Our holding in this case is simply that the insurer's acceptance did not include the subsequently denied conditions.

In the Matter of the Compensation of
ELEANOR BIANCHI, Claimant
WCB Case No. 97-05098
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's current right knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's "Ultimate Findings of Fact." We briefly summarize the findings as follows.

Claimant injured her right knee at work on August 28, 1996. The employer accepted the claim for nondisabling right knee strain. Thereafter, Dr. Versteeg diagnosed a probable small medial meniscus tear and possible articular injury. On April 3, 1997, claimant was examined by Dr. Fuller on behalf of the employer. On May 15, 1997, the employer denied claimant's current right knee condition.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Versteeg, the ALJ found that claimant had established compensability of her current right knee condition. On review, the employer argues that Dr. Versteeg's opinion is unpersuasive because the doctor changed his opinion regarding the cause of claimant's current right knee condition without explanation. The employer further argues that Dr. Fuller's opinion is the most persuasive medical opinion in the record and that based on Dr. Fuller's opinion, its denial should be upheld. We agree with the employer for the following reasons.

The medical evidence addressing the cause of claimant's current right knee condition is limited to the opinions of Drs. Fuller, who examined claimant on behalf of the employer, and Versteeg, claimant's attending physician. In a report to the employer, Dr. Fuller diagnosed claimant's current right knee condition as a degenerative tear of the medial meniscus, probably related to early degenerative arthritis of the medial compartment secondary to claimant's genu varum (bow leg) deformity. Dr. Fuller opined that the major contributing cause of claimant's current condition and need for treatment was her preexisting bilateral genu varum deformity.

Dr. Versteeg initially concurred with Dr. Fuller's report. After conferring with claimant's attorney and reviewing his chart and Dr. Fuller's report, Dr. Versteeg indicated that he believed that the major contributing cause of claimant's initial symptoms was her work. Dr. Versteeg indicated that he believed there was a "chance" that claimant had an ongoing mechanical problem in her knee involving the meniscus or articular cartilage.

Dr. Fuller was deposed. In his deposition testimony, he explained that the basis for his diagnosis of medial compartment arthritis was his finding of crepitus in the medial compartment. Dr. Fuller noted that the type of tear of claimant's meniscus shown on MRI was typical of a tear caused by degeneration as opposed to trauma. In addition, Dr. Fuller noted that the angulation of claimant's knee predisposed her to arthritis, but also indicated that claimant's arthritis was not severe enough to be found on x-rays. After his deposition, Dr. Fuller provided medical literature supporting his opinion that a deviation from a knee with an average of 5 to 7 percent of valgus angulation is "abnormal."

Dr. Versteeg indicated that in order to make a diagnosis of degenerative arthritis, x-ray or MRI evidence or an arthroscopic examination would be necessary. After reviewing Dr. Fuller's testimony, Dr. Versteeg was still of the opinion that claimant's knee condition was caused in major part by her work. Dr. Versteeg did not feel that the varus angulation had caused any degenerative arthritis.

After reviewing the medical evidence, we are not persuaded by the opinion of Dr. Versteeg. In this regard, Dr. Versteeg initially concurred with Dr. Fuller's opinion that the major contributing cause of claimant's current right knee condition and need for treatment was the genu varum deformity. Without explanation, Dr. Versteeg changed his opinion and indicated that he believed that the major contributing cause of claimant's initial symptoms was her work activities and that there was a "chance"

that claimant had an ongoing mechanical problem in her knee involving the meniscus or articular cartilage. Given his unexplained change of opinion, we find Dr. Versteeg's opinion to be unpersuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (medical opinion lacking in explanation and analysis unpersuasive).

We, instead, rely on Dr. Fuller's opinion. We find Dr. Fuller's opinion to be persuasive because it is both well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259 (1986). Dr. Fuller explained that the tear shown on the MRI is typical of a degenerative tear. Thus, although claimant's arthritis has not progressed to the point that it is visible on x-rays, we are nonetheless persuaded by Dr. Fuller's explanation that claimant has degenerative arthritis as a result of an "abnormal" angulation of her knee that combined with her work injury to cause disability and a need for treatment.[1] Accordingly, we accept his opinion that the major contributing cause of claimant's disability and need for treatment of the combined condition is the preexisting genu varum and resulting arthritis. Consequently, we find that claimant has not established compensability of her current right knee condition pursuant to ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated July 29, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[1] Based on Dr. Fuller's opinion, we find that ORS 656.005(7)(a)(B) applies and that, to establish compensability, claimant must prove that the August 1997 injury is the major contributing cause of the disability or need for treatment of the combined condition.

In the Matter of the Compensation of
THOMAS W. CLARK, Claimant
WCB Case No. 98-03916
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its April 17, 1998 partial denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 23 at the time of hearing, experienced the onset of low back pain on July 25, 1997, as he bent over to lift a sheet of drywall. His symptoms continued and, on August 4, 1997, he sought treatment.

He made a claim for a low back injury, which SAIF denied on October 16, 1997. Claimant requested a hearing. The denial was set aside pursuant to a March 23, 1998 Opinion and Order, which directed SAIF to accept a lumbosacral strain.[1]

On April 18, 1998, SAIF submitted a Form 1502 (Insurer's Report) to the Workers' Compensation Division indicating that the form was the "First Report since litigation ordered acceptance" of the claim on March 23, 1998. SAIF further noted that the Opinion and Order was on appeal and the claim was being processed.

[1] We Take Official Notice Of The Fact That The Alj'S March 1998 Opinion And Order Was Affirmed By The Board On August 19, 1998. *See, e.g. Eula M. Zarling*, 50 Van Natta 1189 (1998) (as a general rule, the Board may take official notice of a subsequent litigation order involving the same claim).

While the compensability of the initial injury claim was being litigated, claimant's back pain persisted and he sought follow up treatment with Dr. Ackerman. An August 22, 1997 x-ray showed a transitional lumbosacral segment and spondylolysis and spondylolisthesis at L4-5. In addition, a September 4, 1997 MRI of claimant's lumbar spine showed a central annular bulge at L4-5 without focal disc herniation.

Claimant was examined by Drs. Peterson and Reimer at SAIF's request on October 10, 1997. Drs. Peterson and Reimer opined that claimant's spondylitic defect preexisted his July 25, 1997 work injury, and that the preexisting condition and the work injury combined to cause claimant's need for treatment. The doctors concluded, however, that the preexisting spondylolysis and spondylolisthesis were the major cause of claimant's current combined condition. Claimant's treating doctors, Ackerman and Waldrum, concurred with this report.

On April 17, 1998, SAIF issued a denial of claimant's current disability and need for treatment, asserting that his alleged work injury had ceased to be the major cause of his combined condition. The denial provided, in pertinent part, as follows:

> "* * * By Opinion and Order of March 23, 1998, SAIF Corporation was ordered to accept your claim for a lumbosacral strain. That Order has been appealed by SAIF, in the meantime, procesing of your claim will proceed pursuant to law."
>
> "You have preexisting, noncompensable medical condition(s) which are diagnosed as degenerative disc disease and spondylolisthesis of the lumbar spine at L4 and L5. Your alleged work injury combined with the preexisting conditions, but as of October 10, 1997, your work injury, which is still on appeal, is not the major cause of your combined condition."

Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on *Michael C. Leggett*, 50 Van Natta 151 (1998), the ALJ found that SAIF's partial denial was procedurally impermissible because it denied a combined condition involving claimant's lumbosacral strain - a compensable condition which SAIF had yet to formally accept. On review, SAIF argues that its denial is procedurally valid and appropriate under ORS 656.262(7)(b).[2]

Specifically, citing to *Tracey M. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998) (decided subsequent to the ALJ's order), SAIF asserts that it was required under ORS 656.262(7)(b) to issue a denial of claimant's combined condition prior to claim closure, because the medical evidence establishes that the compensable condition has ceased to be the major contributing cause of claimant's ongoing disability and need for treatment. In response, claimant contends that ORS 656.262(7)(b) is inapplicable, and *Blamires* is distinguishable from this case because his claim had not been "accepted" when SAIF issued the current condition denial. Claimant argues that although SAIF had been directed to accept his lumbosacral strain in the March 23, 1998 Opinion and Order, it had not done so (even conditionally) at the time it issued the April 17, 1998 denial.

In *Tracey M. Blamires*, we expressly disavowed cases such as *Robin W. Spivey*, 48 Van Natta 2363 (1996) and *Michael C. Leggett*, which held that ORS 656.262(7)(b) is applicable 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."

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[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."

Notwithstanding claimant's argument to the contrary, we find that, by virtue of the March 23, 1998 Opinion and Order directing SAIF to accept the claim, claimant's lumbosacral strain claim was in "accepted" status at the time of SAIF's April 17, 1998 denial. We recognize that, as a general rule, whether an acceptance occurs is an issue of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). "Acceptance" has been defined as an act through which the insurer acknowledges responsibility for the claim and obligates itself to provide the benefits due under the law. *Gene C. Dalton*, 43 Van Natta 1191 (1991); *see Jannette I. Shue*, 42 Van Natta 1750 (1990).

In this case, however, "acceptance" resulted from the litigation order. *See, e.g., Richard L. Markum*, 48 Van Natta 2204 (1996) (holding that the carrier had involuntarily accepted the claimant's psychiatric condition pursuant to a prior litigation order finding the condition compensable). Even though SAIF requested review of the March 23, 1998 order, it was statutorily obligated to process the claim as an accepted injury pending appeal. *See, e.g., SAIF v. Maddox*, 295 Or 448 (1983) (the determination of extent of disability is not stayed during litigation of compensability); *Robert E. Wolford*, 45 Van Natta 573 (1993) (although ORS 656.313 stays compensation pending appeal, a carrier is not absolved of its ongoing claim processing obligations). Furthermore, in both the completed 1502 form and the partial denial, SAIF acknowledged that it had been ordered to accept claimant's lumbosacral strain claim and that processing of the claim was proceeding pursuant to law pending appeal of the order. Consequently, for purposes of ORS 656.262(7)(b), we consider claimant's lumbosacral strain claim as "accepted" (albeit involuntarily) as of the March 23, 1998 litigation order.

We acknowledge that, unlike ORS 656.262(6)(c), which includes language describing the nature of the acceptance, *i.e.*, "whether voluntary or as a result of a judgment or order," ORS 656.262(7)(b) does not refer to the means by which the claim is "accepted." But to construe ORS 656.262(7)(b) in the manner proposed by claimant (as requiring that the carrier issue a formal written acceptance of the compensable condition before it can deny the worker's current combined condition prior to closure) could lead to potentially anomalous and unworkable results. Indeed, as a general rule, a carrier is not required to issue a written acceptance of a claim after the claim is found compensable by litigation order. *See SAIF v. Mize*, 129 Or App 636 (1994). We see no logical reason to create an exception to this rule in those instances when, prior to claim closure, the medical evidence indicates that the compensable injury has combined with a preexisting condition and has ceased to be the major cause of the worker's condition. Consequently, we conclude that, once a litigation order directs acceptance of a claim, the claim is "accepted" for purposes of ORS 656.262(7)(b), notwithstanding the carrier's appeal of the order.

Having found that SAIF's April 17, 1998 denial is procedurally appropriate under ORS 656.262(7)(b), we turn to the merits. In his prior March 23, 1998 order, ALJ Menashe specifically found that claimant's compensable lumbosacral strain had ceased to be the major contributing cause of his disability and/or need for treatment as of October 10, 1997 (when claimant was examined by Drs. Peterson and Reimer).[3] This finding represents the law of the case. Because the law of the case dictates that claimant's accepted injury is no longer the major contributing cause of his combined condition, we uphold SAIF's denial.

Finally, even if it was not determined in the prior proceeding, we find that a preponderance of the medical evidence establishes that claimant's compensable lumbosacral strain ceased to be the major contributing cause of claimant's combined condition as of October 10, 1997. Both Dr. Ackerman and Dr. Waldrum concurred with the findings and opinions of Drs. Peterson and Reimer in this regard.

ORDER

The ALJ's order dated September 8, 1998 is reversed. SAIF's April 17, 1998 partial denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[3] In fact, in the prior litigation, claimant conceded that his compensable injury combined with his preexisting condition after he first sought treatment and that, by October 10, 1997, his compensable injury was no longer the major contributing cause of his combined condition. (*See* Ex. 19-3).

In the Matter of the Compensation of
VICKI L. HAVLIK, Claimant
WCB Case No. 98-00608
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the self-insured employer's denial of claimant's claim for a mental 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 adopt the last four paragraphs of the ALJ's order, with the following supplementation.

Claimant's claim for a mental condition is properly analyzed under ORS 656.802. *See Fuls v. SAIF*, 321 Or 151 (1995).

Claimant argues that the ALJ erred in considering "fear of down-sizing" as a stressor, because she reported no such stressor while working for the employer as an animal control officer. We agree. (*See* Ex. 12-6).

Claimant also contends that the ALJ erred in characterizing some of claimant's stressors as excluded from among compensable stressors because they were "conditions other than conditions generally inherent in every working situation." *See* ORS 656.802(3)(b). In addition, claimant argues that she was not stressed by the employer's recent policy changes, only by the *effects* of those changes. We disagree with both arguments.

Claimant reported stress in part due to "continuing problems dealing with management." (Ex. 1-1). She believed that the employer's new management decisionmakers knew nothing about animal control. (Exs. 6, 12-3). Claimant specifically disagreed with new management policies that put an end to quick euthanasia and caused the shelter to be overcrowded. (Exs. 6, 8-1, 12-4).[1] In claimant's view, management's mistaken prioritizing caused numerous stressors, including unexpected schedule changes, understaffing, and inadequate care for overcrowded shelter animals. (*See* Exs. 12-5, 12-6).

But there is uncontradicted evidence that management's scheduling and staffing changes were direct responses to budgetary constraints and the overcrowded conditions resulted largely from reliance on legal advice (regarding the proper holding time for feral cats). These stressors are not compensable because they are conditions "generally inherent in every working situation." *See* ORS 656.802(3)(b). *See Patrick W. Real*, 49 Van Natta 2107 (1997), *aff'd mem* 157 Or App 723 (1998) (Employer's new management methods are conditions generally inherent in all working situations); *Gary W. Helzer*, 47 Van Natta 143, 144 (1995) (New management and administrative procedures are generally inherent in every working situation); *Karen M. Colerick*, 46 Van Natta 930 (1995) (Changes in procedures and altered job descriptions are conditions generally encountered in all working situations).

Finally, because we agree with the ALJ that claimant has not established that cognizable stressors were the major cause of her mental condition,[2] we conclude that the claim must fail. *See Lori*

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[1] Claimant reported her perception that management did not "believe that any animals should have to die[,]" while she felt that "some of it [euthanasia] has to be done." (Exs. 12-4, 8-1).

[2] We acknowledge claimant's contention that the ALJ erred in addressing "medical causation," because the employer did not expressly challenge the sufficiency of the medical evidence. However, the burden of proving compensability rests with claimant. ORS 656.266. Moreover, the employer denied compensability under ORS 656.802 and the statute provides that a claim for a mental disorder is not compensable unless "major causation" is established. ORS 656.802(2)(a). Under these circumstances, we are not persuaded that the employer waived the "major causation/medical evidence" element in denying claimant's mental disorder claim.

Ann Wages, 47 Van Natta 1335, 1337 (1995), *aff'd Bank of Newport v. Wages*, 142 Or App 145 (1996) ("Medical evidence that does not factor out excluded from non-excluded employment conditions under ORS 656.802(3) cannot satisfy a claimant's burden of proving a compensable mental disorder); *Helzer*, 47 Van Natta at 144 (The medical evidence failed to meet the claimant's burden, because it did not exclude from consideration the noncognizable elements set forth in the statute); *Mary A. Murphy*, 45 Van Natta 2238 (1993) (Medical expert's reliance on stressful condition generally inherent in every working situation--job rule/guideline changes--was basis for upholding denial of mental condition).

ORDER

The ALJ's order dated June 3, 1998 is affirmed.

January 20, 1999 Cite as 51 Van Natta 99 (1999)

In the Matter of the Compensation of
WILLIE KEMP, JR., Claimant
WCB Case Nos. 98-03414, 98-02645, 98-01700, 98-01699, 98-00700 & 98-00699
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

On October 22, 1998, we withdrew our September 24, 1998 Order on Review in which we reversed that portion of an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's January 20, 1998 denial of claimant's new injury claim and affirmed that portion of the order that upheld the employer's February 23, 1998 denial of claimant's occupational disease claim. Contending that we should have invoked the last injurious exposure rule as a rule of proof as required in *Gosda v. J.B. Hunt Transportation*, 155 Or App 120 (1998), and, in the alternative, that claimant has established compensability of his current condition as related to either his 1990 or 1993 compensable claims, claimant sought reconsideration.

In order to further consider the matter and to grant the employer an opportunity to respond, we abated our order. Having received the employer's response, we proceed with our reconsideration.

In *Gosda*, the Court of Appeals held that the last injurious exposure rule (LIER) must be invoked as a rule of proof in cases where the medical evidence would otherwise establish compensability. 120 Or App at 125. The court noted that "the undisputed evidence showed that the major contributing cause of the claimant's occupational disease was his work." *Id.* The court found that "claimant's work as a long haul driver caused him to use his hands in ways that ultimately led to his medical condition--*e.g.*, holding a steering wheel that vibrated, switching gears, cinching chains and straps, and loading and unloading items," and noted that "the ALJ determined that all of the medical evidence, including the report of insurer's physician, 'establishe[d] that claimant's work as a truck driver caused his carpal tunnel syndrome.'" *Id.* at 122, 123.

Thus, because the undisputed evidence showed that the major contributing cause of the claimant's occupational disease was his work, the court found that such evidence would have supported a finding of compensability under the LIER rule of proof. The court reasoned that, if the predicate factual findings necessary to establish compensability in the first instance under LIER rule of proof are made, then the rule must be applied, lest a compensable condition be deemed noncompensable.

Here, as discussed in our Order on Review at pages 5 through 7, and in contrast to the evidence in *Gosda*, the medical evidence in this case fails to establish that claimant's work exposures for a variety of employers were the major contributing cause of his low back condition. Rather, the persuasive medical opinions indicate that claimant's spinal degeneration and disc protrusion were caused by a combination of genetics and aging, with claimant's work having only a minimal effect. Thus, even if we were to apply the LIER rule of proof, claimant's claim would fail.

We next turn to claimant's alternative argument that we should set aside the denials related to the compensable 1990 claim or any of the denials that relate to the current lumbar strain condition and need for medical care. Claimant contends that, because we reversed the ALJ's decision setting aside the employer's "new injury" denial, we should exercise our *de novo* review of the record to determine

whether claimant has established a compensable condition. The employer contends that, inasmuch as claimant did not raise or discuss those portions of the ALJ's order prior to the issuance of our Order on Review, we correctly noted that those denials were not at issue on review. We agree.

Claimant knew after the ALJ issued his opinion that the other denials had been upheld. However, the focus of claimant's arguments on review were directed solely to the January 20, 1998 denial of the October 16, 1997 injury claim and the February 23, 1998 occupational disease denial. He did not raise the issue of the compensability of his current low back condition in relation to the other denied claims.[1] Rather, he raised those issues for the first time in his request for reconsideration of our order on review. Therefore, because claimant raised the compensability issue in relation to those denials for the first time on reconsideration, we will not consider the issue. *See Annette E. Farnsworth*, 48 Van Natta 508 (1996) (the issues on review were limited to "back-up" denial, compensability and penalties. Consequently, the issues of estoppel and penalties, which were raised by the claimant for the first time on reconsideration, were not considered); *see also Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994) (Board has discretion not to address issues raised for first time on reconsideration); *Terry Hickman*, 48 Van Natta 1073 (1996); *Stella D. Bales*, 45 Van Natta 1224 (1993). Accordingly, we continue to adhere to our decision upholding the denials in question.

On reconsideration, as supplemented herein, we republish our November 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] The denials upheld by the ALJ which relate to the November 30, 1990 accepted low back strain claim include the October 27 and October 30, 1997 aggravation denials and the October 30, 1997 new medical condition (L4-5 disc herniation) denial (Exs. 73, 78, 90); the January 20, 1998 denial of an August 8, 1997 injury claim (Ex. 82); and the February 23, 1998 new medical condition (L4-5 disc herniation) denials related to claimant's compensable low back strain claims of December 21, 1993 and August 26, 1994 (Exs. 94, 95).

In the Matter of the Compensation of
ROBERT NICKLE, Claimant
Own Motion No. 97-0380M
SECOND OWN MOTION ORDER REVIEWING
CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our November 9, 1998 Own Motion Order Reviewing Carrier Closure, in which we adhered to and republished our September 22, 1998 order in its entirety. With his request, claimant submits November 4, 1998 and November 30, 1998 medical reports from Dr. Rosenzweig. On December 7, 1998, we abated our prior order to allow the SAIF Corporation sufficient time to respond to claimant's motion. The time for a response having expired, we proceed with our reconsideration. On reconsideration, we withdraw our prior orders and replace them with the following order. We base this decision on the following reasoning.

In our September 22, 1998 order, we relied on Dr. Rosenzweig's June 30, 1998 medical report in finding that claimant was medically stationary on July 15, 1998, when SAIF closed his claim. *See Robert Nickle*, 50 Van Natta 1783 (1998). On reconsideration of that order, claimant contended that his condition worsened requiring further surgery, but did not offer any new medical evidence regarding his medically stationary status at the time his claim was closed. As a result, we adhered to our previous order which affirmed SAIF's July 15, 1998 closure. *See Robert Nickle*, 50 Van Natta 2180 (1998).

With his most recent request for reconsideration, claimant submits two medical reports authored by Dr. Rosenzweig in support of his contention that he was not medically stationary when SAIF closed his claim. These reports offer a different opinion regarding claimant's medically stationary status at the time of claim closure. 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. Rosenzweig explained that, when he authored the June 30, 1998 report, he had not seen claimant since April 1998, which led him to conclude that claimant was medically stationary. At the time, Dr. Rosenzweig assumed claimant's condition was stable and that he just needed palliative care in the form of convalescence and therapy.

However, as a result of claimant's worsening in August 1998 which led to a second hip revision in October 1998, Dr. Rosenzweig reevaluated his June 30, 1998 opinion. When Dr. Rosenzweig declared claimant medically stationary on June 30, 1998, he was unaware that claimant's condition was not stable and indeed was getting progressively worse. He explained that claimant had developed weakness of the hip girdle muscles, progressive stretching, and scar tissue subsequent to his December 1997 hip revision. It was when this ongoing progressive worsening led to claimant's eventual need for a second revision, that Dr. Rosenzweig realized that claimant's condition was not and has not been medically stationary since he underwent his first revision in December 1997.

Dr. Rosenzweig's November 30, 1998 opinion was based on a medical examination conducted in August 1998, just one month after SAIF closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the July 15, 1998 Notice of Closure and the August 1998 examination, we conclude that claimant's August 1998 condition, as described in Dr. Rosenzweig's November 1998 opinions, was essentially the same as it was at the July 15, 1998 claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622. Further, Dr. Rosenzweig used objective findings to support his change of opinion. Finally, Dr. Rosenzweig's opinion is unrebutted.

Consequently, we find that Dr. Rosenzweig persuasively explained his change of opinion regarding claimant's medically stationary status. Thus, we conclude that claimant was not medically stationary on July 15, 1998 when his claim was closed by SAIF.

Accordingly, on reconsideration, in lieu of our previous orders, we set aside the Notice of Closure as premature and remand the claim to SAIF for further processing in accordance with law. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.[1] The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In the event that we continued to adhere to our prior findings which affirmed SAIF's Notice of Closure, claimant requested that his claim be reopened for the provision of temporary disability benefits as of the date he underwent his second surgery in October 1998. In light of our finding that the claim was prematurely closed, we have dismissed claimant's "alternative" request for own motion benefits.

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

Claimant requested reconsideration of our September 17, 1998 Own Motion Order on Reconsideration that republished our July 14, 1998 order which declined to reopen her 1983 industrial injury claim for the payment of temporary disability compensation because she failed to establish that she remained in the work force when her compensable condition worsened requiring surgery or hospitalization. With her request for reconsideration, claimant submitted an affidavit in support of her contention that she was in the work force at the time of disability.

On October 19, 1998, we abated our September 17, 1998 order, and allowed the self-insured employer 14 days in which to file a response to the motion.[1] As no response has been received, we will proceed with our review. On reconsideration, we withdraw our prior order, and issue the following order in its place.

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

In support of her contention that she was in the work force at the time of the worsening of her compensable condition, claimant submitted a July 17, 1998 chart note from Dr. Long, her treating physician. Throughout his report, Dr. Long repeatedly opined that, not only was claimant not able to do her job as a unit secretary, but that she was "not fit to do modified work in a sedentary or light capacity." He went on to state that "I would consider that [claimant] was unfit for regular or modified work from the time I initially saw her in January 1993 through mid-July 1995, 3 months following the C5-6 discectomy and fusion." This opinion is unrebutted. We interpret Dr. Long's opinion to be that, prior to the time of her April 18, 1995 disability, it would have been futile for claimant to seek work due to her compensable condition. Thus, we find that claimant has met the second part of the third criterion set forth in *Dawkins, id.*

However, in order to fully satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that she was willing to work. Failing to demonstrate her willingness to work, then she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Arthur R. Morris*, 42 Van Natta 2820 (1990); *Judith R. King*, 48 Van Natta, 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

On reconsideration, claimant submitted an October 16, 1998 affidavit, which outlined her work history and efforts to continue to work despite her disability. In 1988, as a result of her ongoing pain, claimant left her job at a hospital to begin her own home medical care business. In 1990, claimant's compensable injuries worsened to point where she was unable to continue her business. During the period between 1990 and her eventual neck surgery in 1995, claimant sought continuous medical care in efforts to relieve her pain which would enable her to return to work.[2]

Claimant asserts in her affidavit that when she started her company in 1988, "I had every intention of being a successful business woman and running Medical Care for a long time." Despite these intentions, "because of physical problems and medical advice," she terminated her business in 1990.

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[1] On November 16, 1998, acknowledging that the employer's counsel was not served with a copy of our order of abatement, we forwarded a copy to the employer's attorney and granted the employer and/or its attorney 14 days to respond to claimant's submission. To date, no response has been received from the employer and/or its attorney.

[2] The history of claimant's medical treatment is outlined in Administrative Law Judge (ALJ) Johnson's September 4, 1997 Opinion and Order, an order that we affirmed on April 23, 1998. By this reference, we incorporate those orders into our decision.

In 1990, claimant gave a statement to the employer. She reported that she had stopped working to take care of her daughter and was able to do so because her husband was a good provider. As noted above, claimant's October 1998 affidavit provides a more complete explanation as to why she quit working. She acknowledges that when she stopped working she remained at home to take care of her children. However, she also asserts that staying at home watching her children was a consequence of her leaving work, not the reason. Claimant attests that she primarily stopped working because of great physical pain due to her compensable conditions. These complaints and their impact on her physical abilities are confirmed by Dr. Long, her long-time treating physician.

Under such circumstances, we are persuaded that claimant has demonstrated her willingness to work. She established her own business when her compensable conditions made it difficult to continue her hospital work. She continued to work at her home business despite the worsening of her compensable conditions. Claimant sought medical treatment when her conditions worsened to the point where she could no longer continue her home business.

On this record, we conclude that claimant has established that she was willing to work, but that it would have been futile for her to seek work due to her compensable condition.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DONNA R. ROBERTS, Claimant
WCB Case Nos. 98-01244 & 97-08158
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside SAIF's denial to the extent it denied compensability; and (2) awarded a $600 attorney fee to claimant's attorney. Farmers Insurance Group (Farmers) cross-requests review of that portion of the ALJ's order that set aside its compensability and responsibility denial of claimant's left upper extremity condition. On review, the issues are compensability, responsibility and attorney fees. We affirm in part and reverse in part.[1]

FINDINGS OF FACT

Claimant, a dental assistant, worked for Dr. Ross until December 1995. On October 18, 1995, claimant was leaning against a chair when the arm gave way and she fell forward. (Tr. 11, Ex. 9). On the "801" form, claimant explained she had sharp pain from the shoulder to the elbow and into her neck. (Ex. 9). Claimant testified that she had no previous injuries to her left shoulder or neck. (Tr. 13).

On October 20, 1995, Dr. Geddes reported that claimant's back and shoulders hurt so bad that she was getting headaches. (Ex. 7-1). Five days later, Dr. Geddes said that claimant's pain was radiating up into her neck. (Ex. 7-2). He referred claimant to Dr. Rosenbaum, who felt that claimant had C8 radiculopathy. (Ex. 11). Dr. Rosenbaum prescribed physical therapy and treated claimant

[1] We modify the ALJ's order to note that Exhibits 1 through 71 and 57A were admitted in evidence.

conservatively. (Ex. 12, 14, 15). On December 6, 1995, the physical therapist reported that claimant was "80% over her symptoms" and claimant was "very pleased" with her progress. (Ex. 15-1). Dr. Rosenbaum reported on December 15, 1995 that claimant was "significantly" improved with physical therapy. (Ex. 18-1). Claimant's last visit with Dr. Rosenbaum was on January 9, 1996, where he reported a "[r]esolution of all symptoms except residual lateral deltoid discomfort." (Ex. 21). She was discharged from physical therapy on January 12, 1996. (Ex. 22).

SAIF accepted a nondisabling cervical strain. (Ex. 16). On March 19, 1996, the SAIF claim was closed administratively because claimant had not sought medical treatment for more than 30 days. (Ex. 25).

Claimant testified that her condition in 1995 improved with treatment. (Tr. 14, 15). She said, however, that her symptoms after the injury while employed by Dr. Ross did not totally subside. (Tr. 46).

On December 4, 1995, claimant began working for Dr. Evans as a head dental assistant. (Tr. 15, 16). She also worked for Dr. Ross at times in March 1996, April 1996, July 1996 and August 1996 when Dr. Evans was on vacation. (Tr. 68, 72).

Because Dr. Evans was left-handed, claimant turned more to her left and used her left arm to obtain instruments. (Tr. 16, 17). Her job duties also included putting supplies away and doing cleanup. (Tr. 18). On March 14, 1997, claimant sought medical treatment from Dr. Geddes for left shoulder pain. (Tr. 23, Ex. 29). He reported that claimant had pain over her left rhomboid and trapezius muscle, and there was definite tightness and spasm. (Ex. 29-2). He recommended a "Tens" unit and physical therapy. (*Id.*)

On July 23, 1997, Dr. Geddes took claimant off work for two weeks. (Ex. 31-1). He reported on August 6, 1997 that claimant's pain continued to a moderate degree, even though she had been off work. (Ex. 31-2). On August 14, 1997, Dr. Geddes signed a "Notice of Claim for Aggravation of Occupational Injury or Disease." (Ex. 36). Claimant signed an "801" form on September 18, 1997. (Ex. 44). On September 24, 1997, SAIF, on behalf of Dr. Ross, denied claimant's aggravation claim and also denied responsibility for claimant's "current condition diagnosed as left shoulder strain, left ulnar neuropathy, possibly left carpal tunnel syndrome and migraine headaches." (Ex. 45). Claimant requested a hearing.

Dr. Geddes referred claimant to Dr. Ward, a "rehab" specialist. (Ex. 39). Dr. Ward examined claimant on September 24, 1997. (Ex. 46). He recommended medication, physical therapy and an MRI to rule out possible cervical radiculopathy. (Ex. 46-5).

An MRI on October 13, 1997 showed a tiny left paracentral disc bulge at C5-6 without spinal cord or nerve root compression. (Ex. 50-1). The thoracic spine MRI was negative. (*Id.*) The left shoulder MRI showed a small amount of fluid in the subacromial/subdeltoid bursa and the subcoracoid bursa, suggesting bursitis. (Ex. 50-2).

Dr. Geddes referred claimant to Dr. Smith. (Ex. 48). On October 27, 1997, Dr. Smith reported that claimant had left subacromial pain with some elements of impingement tendinitis. (Ex. 53-2). He injected claimant's shoulder. (*Id.*) Dr. Smith reported that claimant was "fairly histrionic" and he felt there may be some overlying functional features. (*Id.*)

On December 3, 1997, claimant's attorney sent a "new medical condition" claim to SAIF, requesting that it accept or deny a "left paracentral disc bulge at C5-6 with partial effacement of the ventral subarachnoid space, left shoulder bursitis."[2] (Ex. 57). On the same date, claimant's attorney sent notice of the same claim to Farmers. (Ex. 57A).

On December 30, 1997, Farmers denied compensability and responsibility of claimant's left upper extremity, back, neck and head conditions. (Ex. 62). Claimant requested a hearing.

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[2] At hearing, claimant withdrew her claim for a C5-6 disc bulge condition. (Tr. 3).

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ determined that claimant's condition in 1997 was not the same condition that she had in 1995. The ALJ relied on the opinions of Drs. Geddes and Ward and concluded that claimant's work with Dr. Evans was the major contributing cause of her current left shoulder condition.

To begin, we address Farmers' argument that the extent of the medical condition accepted by SAIF included the shoulder and other body parts affected by the cervical strain, not just claimant's neck.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. *Johnson v. Spectra Physics*, 303 Or 49, 56 (1987). Whether an acceptance occurs is a question of fact. *SAIF v. Tull*, 113 Or App 449, 454 (1992). Here, SAIF specifically accepted a nondisabling cervical strain. (Ex. 16). Even if we assume, without deciding, that claimant's shoulder and other body parts were "affected" by the cervical strain, SAIF did not accept those conditions. Rather, the only condition accepted by SAIF was a cervical strain. *See Kim D. Wood*, 48 Van Natta 482, 484 (because there was a specific acceptance, it was not necessary to examine the contemporaneous medical evidence to determine what condition was accepted), *aff'd mem* 144 Or App 496 (1996).

Farmers argues that claimant failed to establish that her work for Dr. Evans was the major contributing cause of her disability and need for treatment. Farmers contends that claimant did not sustain a "new injury" while employed by Dr. Evans and SAIF cannot shift responsibility under ORS 656.308(1).

Because claimant has a previous accepted claim, we first determine whether ORS 656.308(1) applies to this case. 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 the accepted claim. *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).

As a result of the 1995 claim, SAIF accepted a cervical strain. (Ex. 16). The record does not establish a clear diagnosis for claimant's current left upper extremity symptoms. Nevertheless, we find that the persuasive medical opinions establish that her current left upper extremity symptoms are not the same as the condition previously accepted by SAIF.

Dr. Geddes, claimant's treating physician, testified that, although he initially felt claimant's current condition was related to the 1995 injury, he no longer held that opinion. (Ex. 70-52, -53). He did not believe claimant's current symptoms were related to the 1995 injury and he explained that claimant had developed more shoulder symptoms and less neck and finger symptoms in 1997. (Ex. 70-53). Dr. Geddes agreed with Dr. Ward's opinion that claimant's 1995 injury had resolved and was no longer contributing to the current symptoms and need for treatment. (Ex. 70-54). Dr. Geddes was aware that claimant had some problems off and on with her left shoulder after January 1996, but she did not seek treatment for those problems until March 1997. (Ex. 69-2).

Dr. Ward had agreed that claimant's problems related to the 1995 injury had resolved by January 1996 and there was a 14-month period of time in which claimant sought no medical treatment. (Ex. 66-2). Dr. Ward adhered to his opinion in a deposition. (Ex. 71-32). Dr. Wilson examined claimant on behalf of SAIF and concluded that claimant's symptoms from the 1995 injury had resolved by January 1996 and he did not believe that her current condition was related to the 1995 injury. (Ex. 64-3). Dr. Schilperoort diagnosed "possible left shoulder strain associated with on-the-job exposure October 18, 1995, resolved." (Ex. 59-5).

On the other hand, Dr. Smith agreed in a concurrence letter from claimant's attorney that the major contributing cause of claimant's "tendonitis/bursitis of the left rotator cuff/left shoulder strain" condition and need for treatment was the October 1995 injury. (Ex. 65-2). Dr. Smith examined claimant

on only one occasion, on October 27, 1997, more than two years after the 1995 injury. (Ex. 53). Dr. Smith did not discuss the medical reports indicating claimant's 1995 injury had resolved, particularly Dr. Rosenbaum's January 1996 report that claimant had a "[r]esolution of all symptoms" except residual deltoid discomfort. (Ex. 21). We are not persuaded by Dr. Smith's opinion because it is conclusory and lacks adequate explanation. *See Marta I. Gomez*, 46 Van Natta 1654 (1994) (Board will give little weight to conclusory, poorly reasoned opinions, such as unexplained "check-the-box" reports).

Based on the opinions of Drs. Geddes, Ward and Wilson, we conclude that claimant's 1995 accepted condition is not the "same condition" as her current left upper extremity condition. Therefore, ORS 656.308(1) does not apply.

Claimant asserts that she sustained a "new left shoulder injury" while employed by Dr. Evans. She relies on the opinions of Drs. Geddes and Ward to establish compensability.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard v. Renalds*, 132 Or App 288 (1995)). We note that claimant does not have to prove a specific diagnosis in order to prove her claim. *Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992). We find that the record does not support the occurrence of an "injury" while claimant was employed by Dr. Evans. Claimant's symptoms arose gradually and she was unable to identify a specific event while working for Dr. Evans that precipitated the onset of her symptoms. Thus, we conclude that claimant's left upper extremity claim more properly relates to an ongoing condition with a gradual onset rather than an "event." *See Mathel v. Josephine County*, 319 Or 235, 240 (1994); *James v. SAIF*, 290 Or 343, 348 (1981); *Valtinson v. SAIF*, 56 Or App 184, 187 (1982). Thus, we conclude that her claim is most appropriately characterized as an "occupational disease."

Under ORS 656.802(2)(a), claimant must establish that her employment conditions were the major contributing cause of her left upper extremity condition.

The insurer argues that claimant's complaints were "purely subjective" and were accompanied by histrionic and underlying functional behavior.

Under ORS 656.005(19), 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' do not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

The insurer relies on a report from Dr. Smith that claimant was "fairly histrionic, sobbing and moving around a lot[.]" (Ex. 53-2). Dr. Smith's comments were made after he had injected claimant's shoulder and he noted that he was not sure the entire amount was accurately placed in the subacromial space. (*Id.*) Dr. Geddes indicated it was possible that Dr. Smith did not inject the right area. (Ex. 70-40). In light of the possibility that Dr. Smith injected the wrong area, we are not persuaded that claimant was "histrionic" at the time of his examination.

The insurer also relies on a report from Dr. Schilperoort to argue that claimant had functional overlay. (Ex. 59-5, -6). Drs. Smith and Schilperoort each examined claimant on one occasion. We are more persuaded by the reports from claimant's treating physician, who had the opportunity to treat claimant on several occasions. Dr. Geddes reported on March 14, 1997, that claimant had pain over her left rhomboid and trapezius muscle and he felt "definite tightness and spasm." (Exs. 29-2, 70-18). He believed that the MRI findings were consistent with bursitis. (Exs. 69-2, 70-64). The October 13, 1997 MRI showed a small amount of fluid in the subacromial/subdeltoid bursa and the subcoracoid bursa, suggesting bursitis. (Ex. 50-2).

Dr. Ward also reported findings that constituted "objective findings" under ORS 656.005(19). During Dr. Ward's examination on September 24, 1997, he reported that claimant had tenderness throughout the symptomatic area with "definite tender points in the left upper trapezius, left medial trapezius, left infraspinatus, left serratus anterior insertion and left pectoral areas." (Ex. 46-5). He testified that the tender point was a "real" or objective finding. (Ex. 71-20). He found no pain behavior. (Ex. 46-4). Although Dr. Ward reported mild giveaway on strength testing in the left upper extremity

when he examined claimant (Ex. 46-4), he performed two other "validity tests" on claimant that were not abnormal. (Ex. 71-36, -37). Based on the reports from Drs. Geddes and Ward, we conclude that claimant had "objective findings" of a left upper extremity condition.

Because of passage of time and the number of potential causes of claimant's left upper extremity condition, the causation issue presents a complex medical question requiring competent medical evidence. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 282 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reason not to rely on Dr. Geddes' opinion.

Dr. Geddes testified that he first treated claimant for left upper extremity problems on October 20, 1995. (Ex. 70-5). On that date, he reported that her back and shoulders hurt so bad that she was getting headaches from them. (Ex. 7-1). Five days later, he reported that claimant's pain was radiating into her neck and both sides. (Ex. 7-2). Dr. Geddes referred claimant to Dr. Rosenbaum, who treated claimant until January 1996. (Ex. 21).

Claimant sought treatment from Dr. Geddes for left shoulder pain on March 14, 1997. (Ex. 29). He recommended a "Tens" unit and physical therapy. (*Id.*) On June 25, 1997, Dr. Geddes felt that claimant had "classic overuse syndrome involving the traps, rhomboids, and upper shoulder muscles and especially the supraspinatus tendon and in the upper deltoid area." (Ex. 29-3). Dr. Geddes felt that rotation of her body, twisting, turning and using her left arm with the dental procedures had caused discomfort and spasm. (*Id.*)

On July 23, 1997, Dr. Geddes reported that claimant had continued problems with her left shoulder and he recommended claimant be off work for two weeks. (Ex. 31-1). Dr. Geddes reported on August 6, 1997 that claimant had been off work and had not moved her arm much, but her pain continued to a moderate degree. (Ex. 31-2). He recommended nerve conduction tests, which were normal. (Exs. 31-2, 70-28).

On August 14, 1997, Dr. Geddes signed a "Notice of Claim for Aggravation of Occupational Injury or Disease." (Ex. 36). He continued to treat claimant through December 1997. (Ex. 70-43). Dr. Geddes indicated on April 2, 1998 that his ultimate diagnosis was a left shoulder strain/left shoulder bursitis, as well as a cervical strain. (Ex. 69-1). His overall diagnosis was an overuse syndrome. (*Id.*, Ex. 67-2).

Although Dr. Geddes initially felt that claimant's current left shoulder condition was related to the 1995 injury claim (Exs. 36, 70-16), he subsequently concluded that the major contributing cause of her current condition was her work activities for Dr. Evans. (Ex. 69, 70-63). He testified that claimant's 1995 condition had resolved by January 1996, and he agreed with Dr. Ward that the 1995 injury was no longer contributing to her current symptoms. (Exs. 70-11, -54). Dr. Geddes was aware that claimant had some problems off and on with her left shoulder after January 1996, but she did not seek treatment for those problems until March 1997. (Ex. 69-2). In a concurrence letter from claimant's attorney, Dr. Geddes agreed that the major contributing cause of claimant's current condition was her work for Dr. Evans, which began in December 1995. (Ex. 69-2). His opinion was supported by claimant's history and the mechanism of her work at Dr. Evans' office. (*Id.*) He agreed that claimant had been working significant hours at Dr. Evans' office, and was using her upper extremities a good deal and was working in a somewhat contorted fashion. (*Id.*) He noted that the findings on the October 18, 1997 MRI were consistent with a left shoulder bursitis. (*Id.*, Ex. 70-64). In a deposition, Dr. Geddes explained that inflammation can sometimes take a long time to subside and he agreed that, once inflammation starts, rather benign use of the extremity can reactivate the inflammation. (Ex. 70-62, -63). Dr. Geddes had treated other dental assistants who had similar problems, due to the contorted and somewhat repetitive nature of their work. (Ex. 69-2). Because Dr. Geddes adequately explained his change of opinion and it is well-reasoned, we find it persuasive.

The insurer argues that Dr. Geddes is not persuasive because he disregarded his own records and asserted that claimant had no shoulder complaints in 1995. The insurer relies on Dr. Geddes'

statement that he had reviewed claimant's chart and "most of the symptoms seem to be related around the shoulder, which was not an issue with the '95 injury." (Ex. 70-31). The insurer is correct that Dr. Geddes' chart notes in October 1995 referred to claimant's shoulder complaints. (Ex. 7). On October 25, 1995, however, he reported that claimant's pain was radiating into her neck. (Ex. 7-2). The medical reports in 1995 focused on claimant's neck pain. On October 31, 1995, Dr. Rosenbaum reported that claimant had C8 radiculopathy (Ex. 10, 11), and he treated her left neck and trapezius pain. (Ex. 12). The physical therapist said that claimant's signs and symptoms were consistent for cervical strain. (Ex. 14). In a deposition, Dr. Geddes explained that claimant's shoulder pain was more significant in 1997, and her pain was more intense and widespread. (Ex. 70-17, -48). We find that Dr. Geddes had an accurate understanding of claimant's symptoms.

Dr. Geddes' opinion on causation is supported by that of Dr. Ward. In a concurrence letter from claimant's attorney, Dr. Ward agreed that claimant's current condition was a cervical strain, left shoulder strain and left shoulder bursitis. (Ex. 68-2). He agreed that claimant's employment with Dr. Evans was the major contributing cause of her current condition, disability and need for treatment. (*Id.*) He agreed that, although claimant did not have a specific traumatic event while working for Dr. Evans, she repetitively used her extremities. (*Id.*) He adhered to those conclusions in a deposition. (Ex. 71-44). Dr. Ward explained that strains can sometimes take years to heal and a few people do not seem to heal from strains. (Ex. 71-46).

The insurer relies primarily on Dr. Smith's opinion on causation. As we discussed earlier, Dr. Smith agreed in a concurrence letter that the October 1995 injury was the major contributing cause of claimant's "tendonitis/bursitis of the left rotator cuff/left shoulder strain" condition and need for treatment. (Ex. 65-2). For the reasons discussed previously, we are not persuaded by Dr. Smith's opinion because it is conclusory and lacks adequate explanation.

The remaining opinions from Drs. Zivin, Wilson and Schilperoort are not persuasive. Dr. Zivin examined claimant on one occasion in November 1997 and recommended further tests. (Ex. 55). In a later report, Dr. Zivin reported that it was difficult to associate claimant's symptoms with her employment with Dr. Evans because her problem was of "such a mild degree." (Ex. 63-2). We are not persuaded by Dr. Zivin's opinion because it lacks adequate explanation.

Similarly, we do not find Dr. Wilson's opinion persuasive. He was not sure why claimant's condition had worsened in spring 1997, but he felt it was either a "spontaneous worsening or somehow related to her employment with Dr. Evans." (Ex. 41-8). In a later report, Dr. Wilson reviewed additional records and reported that claimant had been working for Dr. Evans about a year and four months "when her symptoms got worse 'spontaneously' without any subsequent injuries or occupational exposures." (Ex. 64-3). He concluded that the cause of her left shoulder pain was "quite obscure[.]" (Ex. 64-4). Despite the lack of a specific diagnosis, we are more persuaded by the opinions of Drs. Geddes and Ward that claimant's current condition is related in major part to her work activities with Dr. Evans.

Dr. Schilperoort reported that the only abnormalities on his examination were decreased range of motion in the left shoulder and abnormal sensory examination. (Ex. 59-6). Because of inconsistencies between claimant's stated symptoms and the physical examination findings, he was unable to confirm that claimant suffered from an injury. (*Id.*) We previously determined that claimant's left upper extremity findings constituted "objective findings" under ORS 656.005(19). We note that Dr. Schilperoort examined claimant on only one occasion. In contrast, we are more persuaded by the causation opinion of Dr. Geddes, who had an opportunity to treat claimant on several occasions.

In sum, we conclude that claimant's work activities for Dr. Evans were the major contributing cause of her left upper extremity condition. Consequently, we affirm the ALJ's decision to set aside Farmers' compensability and responsibility denial.

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

Attorney Fees

The ALJ set aside that portion of SAIF's September 24, 1997 denial that denied compensability and awarded a $600 attorney fee to claimant's attorney. The ALJ upheld SAIF's denial of responsibility.

SAIF argues that, even assuming that its denial was a denial of compensability, the ALJ improperly ordered SAIF to pay an assessed fee. SAIF contends that, because the responsibility portion of its denial was upheld, claimant did not "finally prevail" over the denial and is not entitled to an attorney fee.

Claimant contends that SAIF rescinded the compensability portion of its denial before the hearing, but after claimant had requested a hearing on SAIF's denial. Claimant relies on *Elizabeth H. Nutter*, 49 Van Natta 829 (1997), to argue that, because SAIF rescinded its compenability denial, he is entitled to an attorney fee under ORS 656.386(1) for being instrumental in obtaining a rescission of that denial.

Even if we assume, without deciding, that SAIF denied compensability, we are not persuaded that SAIF rescinded its compensability denial before the hearing. At hearing, SAIF's attorney asserted that there were no compensable conditions as to Dr. Ross. (Tr. 4). SAIF's attorney explained: "There may or may not be compensable conditions as to Dr. Evans. But anything that -- any compensable condition that [claimant] may have is not compensable as to Dr. Ross. It's not related to Dr. Ross -- anything that she may have." (*Id.*) We are not persuaded that SAIF rescinded any portion of its denial. SAIF continued to argue that claimant's current condition was not related to the employment of Dr. Ross or the accepted 1995 claim. (Tr. 7).

Under ORS 656.386(1), a claimant's attorney is entitled to a reasonable attorney fee for cases involving denied claims where the claimant "prevails finally" in a hearing. In *Safeway Stores, Inc. v. Hayes*, 119 Or App 319 (1993), the court explained that ORS 656.386(1) permits the assessment of an attorney fee award against a nonresponsible insurer, if that insurer denied compensability, thereby preventing issuance of an order designating a paying agent under ORS 656.307.

Here, in contrast, both the responsible carrier, Farmers, and the nonresponsible carrier, SAIF, denied the compensability of claimant's current condition. Claimant did not "finally prevail" over SAIF's denial. Because SAIF's denial was upheld, rather than set aside, no attorney fee award is authorized because claimant failed to prevail over its denial. *See Rita R. Lovelace*, 47 Van Natta 167 (1995). Accordingly, we reverse the ALJ's $600 attorney fee award against SAIF.

ORDER

The ALJ's order dated July 15, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside SAIF's denial and directed SAIF to pay a $600 attorney fee to claimant's attorney is reversed. SAIF's denial is upheld in its entirety. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by Farmers Insurance Group.

In the Matter of the Compensation of
JAMES E. SMITH, Claimant
WCB Case No. 97-05999
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its July 17, 1997 denial of claimant's then-current cervical condition; and (2) assessed an attorney fee of $3,500 for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant, a construction worker in his early 50s, was compensably injured on April 7, 1997 while removing concrete form lumber (ledger boards) from an area under a bridge. Claimant was on his knees, working with a pry bar when a 2x6 board came loose suddenly and struck him in the face. The blow knocked him back, and he landed on his outstretched right arm. Claimant sustained a puncture wound to his right hand (from a nail or rebar), an injury to the right shoulder and a cervical strain.

Claimant reported the injury and, on April 8, 1997, sought treatment for the puncture wound. He returned for a recheck on April 18, 1997, complaining of neck and right shoulder pain. An April 25, 1997 MRI of the cervical spine showed right sided abnormalities at several levels, including a prominent disc with osteophyte at C2-3, and small disc protrusions at C5-6 and C6-7 on the right as well as some facet joint arthritis.

On May 22, 1997, claimant came under the care of Dr. Gallo. He complained of a sharp, cramping, burning pain radiating from the right side of his neck down the right arm to the elbow, and headaches at the base of his skull. Dr. Gallo diagnosed neck and right shoulder pain with a normal neurologic examination. Suspecting a right rotator cuff injury, Dr. Gallo referred claimant to Dr. Butters for further evaluation of the shoulder.

Claimant saw Dr. Butters on June 16, 1997, and he was diagnosed with a frozen right shoulder related to his work-related fall. Dr. Butters injected claimant's shoulder and recommended physical therapy. This treatment provided significant improvement of claimant's right shoulder complaints.

On June 24, 1997, claimant was examined by Dr. Strum at SAIF's request. He noted, among other things, decreased general usage of claimant's right forequarter, positive impingement signs of the right shoulder and tenderness in the cervical and right shoulder areas. He diagnosed cervical strain and subacromial traumatic impingement related to the work injury and preexisting multiple level cervical disc disease, which did not appear to be clinically symptomatic at that time.

Claimant saw Dr. Gallo on July 14, 1997 and reported headaches but no arm pain. Dr. Gallo reexamined claimant and found no demonstrable neurologic deficit. On July 31, 1997, claimant returned to Dr. Gallo complaining of continued pain in the right shoulder. Suspecting that the pain was radicular, Dr. Gallo sent claimant for a selective nerve block of the right C5 root. The nerve block provided claimant temporary relief.

On September 15, 1997, Dr. Gallo opined that claimant had ongoing cervical nerve root entrapment due to disc bulging, which was causing his neck and right shoulder radicular pain and limited range of motion.

In October 1997, Dr. Strum reported that claimant did not show signs of radiculopathy during his June 24, 1997 examination. Dr. Strum opined that if claimant subsequently developed symptoms and there were true clinical findings of radiculopathy, the condition would be related to claimant's preexisting multiple level degenerative disc disease rather than residuals of the April 7, 1997 work injury.

Dr. Gallo performed surgery (right foraminotomies at C4-5, C5-6 and C6-7) on November 4, 1997. Her surgical findings included moderately severe bony foraminal stenosis at all three levels and, at C4-5, a disc bulge but no obvious free fragment herniation and no significant compression of the nerve root.

In a subsequent report, Dr. Gallo opined as follows:

> "[Claimant's] injury of 4/7/97 caused the lateral disc bulging at all three levels, which, superimposed on his preexisting bony foramenal stenosis, resulted in increased nerve root entrapment and radicular pain, thus necessitating his need for treatment and surgery."

CONCLUSIONS OF LAW AND OPINION

At issue in this proceeding is the compensability of claimant's cervical condition as of SAIF's July 17, 1997 denial.[1] Relying on the opinion of Dr. Gallo over the contrary assessment of Dr. Strum, the ALJ found that claimant had established that his April 7, 1997 work injury was the major contributing cause of his cervical condition and need for treatment.

On review, SAIF contends that Dr. Gallo's opinion is insufficient to carry claimant's burden of proof under the "major contributing cause" standard. We agree, for the reasons set forth below.

Because claimant has a preexisting condition of the cervical spine (including bony foraminal stenosis) that combined with his compensable injury to cause or prolong his disability and/or need for treatment, ORS 656.005(7)(a)(B) requires that he show that his work injury is the major contributing cause of the need for treatment or disability of his combined condition. To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributes more to his combined cervical condition or need for treatment of that condition than all other factors combined. *See, e.g. McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the work injury is more of a contributory factor than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994). The fact that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.*; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Here, although Dr. Gallo related claimant's increased nerve root entrapment and radicular pain to his work injury, she did not explain why the work injury contributed more to claimant's cervical condition or need for treatment than his preexisting, underlying multiple level degenerative disc disease. Dr. Gallo's opinion indicates that claimant's work injury precipitated his radicular symptoms, but we do not find it persuasive evidence that the work injury was the major contributing cause of his need for treatment and surgery. Indeed, although Dr. Gallo believed that claimant had cervical nerve root entrapment due to disc bulging and that the disc bulging was due to claimant's April 7, 1997 injury (*see* Ex. 12), her surgical report indicates that the nerve root compression was due to the preexisting condition, *i.e.*, the moderately severe bony foraminal stenosis, rather than the disc bulges.[2] (Ex. 17).

In addition, Dr. Gallo did not explain her causation opinion in light of her previous findings that claimant had "no arm pain" and "no demonstrable neurological deficit" at the time of his July 14, 1997 follow up examination. These mid-July 1997 examination findings were consistent with Dr. Strum's findings on June 24, 1997. On his examination of claimant, Dr. Strum found no evidence of radiculopathy at any level and concluded that claimant's preexisting degenerative disc disease was not

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[1] Claimant's cervical strain and right shoulder injury were found compensable pursuant to a prior litigation order.

[2] For example, Dr. Gallo reported that, at C4-5, there was moderately severe bony foraminal stenosis and the nerve root was carefully decompressed. Dr. Gallo also found a disc bulge "but no obvious free fragment herniation and this did not appear to be compressing the nerve root significantly so it was not attempted to resect the bulge." Dr. Gallo also reported that similar procedures were performed at C5-6 and C6-7 "with similar findings." The tightest of the foramenal stenosis was found at C5-6, which Dr. Gallo generously decompressed. (*See* Ex. 17).

clinically symptomatic. Because Dr. Gallo did not address these inconsistencies (*i.e.*, the absence of neurological deficits and/or findings indicative of radiculopathy until late July 1997[3]) we find her causation opinion unpersuasive. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980) (conclusory and unexplained medical opinion rejected).

Finally, because we have determined that claimant has not sustained his burden of proof on compensability, we need not address SAIF's challenge to the ALJ's attorney fee award.

ORDER

The ALJ's order dated November 24, 1997 is reversed. SAIF's July 17, 1997 denial, insofar as it denied claimant's current cervical condition, is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[3] On her initial examination of claimant on May 22, 1997, Dr. Gallo reported that claimant had "neck pain and mainly right shoulder area pain with a normal neurologic examination." (Ex 4-5).

In the Matter of the Compensation of
DONALD A. COOK, Claimant
WCB Case No. 98-02872
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's injury claim for a recurrent ventral hernia; and (2) assessed a $2,750 attorney fee for services at hearing. SAIF also moves for remand. On review, the issues are compensability, 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 found claimant's recurrent ventral hernia compensable, based on the opinion of Dr. Hoversten, treating physician. With regard to an attorney fee, the ALJ wrote that, "[i]n light of the factors set out in OAR 438-015-0010(4), especially the time claimant's attorney likely reasonably devoted to this matter, the benefit to claimant by prevailing, and the risk that claimant's attorney would go uncompensated, a reasonable assessed fee is $2,750."

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]

[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.

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.

Here, as in *Underwood*, 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 2332.

Finally, in addition to the ALJ's discussion, we provide the following reasoning. With regard to the time factor, we note that the hearing lasted 45 minutes and claimant was the only witness who testified. The record was made up of 22 exhibits, with at least one opinion letter generated by claimant's attorney.

The compensability issue was of average complexity, considering the range of issues presented to the Hearings Division for resolution. The value of the interest involved and the benefit secured for claimant were more than average because claimant required surgery. Because the medical reports concerning the etiology of claimant's condition 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 value of the interest involved and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $2,750 is a reasonable attorney fee.

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, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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 defending the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.* 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 31, 1998 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the SAIF Corporation.

Board Member Haynes dissenting.

Claimant suffered a fourth "recurrent ventral hernia" when he lifted a car tire at work on January 8, 1998.

It is clear and undisputed that claimant's prior hernias and hernia surgeries predisposed him to further hernias by weakening his abdominal wall. It is also clear and undisputed that this predisposition combined with the 1998 injury to cause the most recent hernia. The question is whether the 1998 lifting incident at work contributed more to claimant's current condition than did all other contributing causes combined. ORS 656.005(7)(a)(B). *See McGarrah v. SAIF*, 296 Or 145, 146 (1983); *Dethlefs v. Hyster Co.*, 295 Or 298, 309-310 (1983).

The majority finds the opinion of Dr. Hoversten, treating surgeon, "sufficient to show major causation," for two reasons. First, the majority states that Dr. Hoversten's ability to examine the hernia during surgery was significant. Second, because the doctor differentiated the cause of claimant's current disability and need for treatment from the causes of the three prior hernias, the majority reasons that Dr. Hoversten thus identified the primary cause of claimant's most recent need for hernia repair surgery (rather than merely the precipitating cause).

But Dr. Hoversten never said that surgical findings supported, or even influenced, his causation opinion. Simply distinguishing one hernia from three prior hernias does not lead to identification of the major cause of the former. The majority's conclusion does not follow its reasoning.

This case is very much like *Robinson v. SAIF*, 147 Or App 157 (1997), a case involving a predisposition to hernias and a "combined" hernia condition. In *Robinson*, the claimant's treating physician

> "could not say what was the major cause of claimant's hernia. He was only able to agree that claimant's work activity was the major cause of claimant's 'symptoms and problems,' that it was what brought him to [the doctor's] office, and that it was the major cause of claimant going from an asymptomatic state to a one that was symptomatic. That testimony shows that claimant's work injury *precipitated* his need for treatment." *Robinson*, 147 Or App at 164 (emphasis added).

The court stated:

> "The fact that a work injury caused or precipitated a claimant's condition does not necessarily mean that that injury was the major contributing cause of the condition." *Id.* at 162 (citing *Dietz v. Ramuda*, 130 Or App 397(1994), *rev dismissed* 321 Or 416 (1995).

The court also noted that the *Robinson* claimant did not explain why the major contributing cause of the need for treatment in that case should be different from the major cause of the hernia itself. (*Id.*). Consequently, the cause of the condition and the cause of the need for treatment were the same in *Robinson*. And the claim was not compensable because the medical opinion supporting the claim was based on mere precipitating cause analysis, with no weighing of the noncompensable predisposition.

Here, claimant relies on Dr. Hoversten, who initially opined:

> "The major cause of [claimant's] problem, I think, is a combination of a very weak anterior abdominal wall fascia manifested by his multiple recurrent hernias and the fact that he still has to be employed at a job where he does a significant amount of lifting and straining. It would be very difficult for me to differentiate which one is the most significant factor, except that he is able to relate a specific incident on a specific date that his lifting at work was the primary cause of his recurrent hernia." (Ex. 17).

Later, Dr. Hoversten summarily agreed that "[t]he major contributing cause of [claimant's] **current** *need for treatment* (including surgery) with respect to his ventral hernia is the January 8, 1998 lifting event." (Ex. 21-2).

Here, as in *Robinson*, claimant offers no explanation why the major cause of claimant's need for treatment should be considered different from the major cause of his condition or "problem." *See SAIF v. Nehl, on recon* 149 Or App 309, 313 (1997) (discussing *Robinson*). Also as in *Robinson*, there is no indication that the medical evidence supporting the claim weighed the undisputed contribution from

claimant's predisposition (his "very weak abdominal wall") in evaluating causation.[1] As in *Robinson*, the medical evidence merely indicates that the work injury precipitated the hernia.

Moreover, Dr. Hoversten did not explain why it was initially "very difficult" to assess major causation, but he was later able to conclude that the work injury was the major contributing cause of claimant's need for treatment.[2] The only apparent basis for the doctor's eventual conclusion is his prior reliance on *claimant's* ability to relate his most recent problem to a specific incident at work on January 8, 1998. But neither claimant's opinion regarding causation nor the temporal relationship between the injury and the subsequent need for treatment is sufficient to establish major causation.[3]

Finally, because Dr. Hoversten's status as treating surgeon did not help him assess causation, his opinion should not be accorded deference on this basis.[4] Under these circumstances, I would hold that claimant has not established that the 1998 work injury was the major cause of his condition *or* his need for treatment for the condition. For these reasons, I must respectfully dissent.

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[1] *See Oreste A. Chorney*, 50 Van Natta 498, *on recon* 50 Van Natta 818 (1998).

[2] *See Michael A. Bracken*, 45 Van Natta 2126, 2127 (1993) (When a doctor finds a condition work-related, without explaining away previously expressed doubts, the ultimate conclusion is not persuasive); *Yann You*, 49 Van Natta 602 (1998), *aff'd mem* 152 Or App 248 (1998) (same).

[3] *See Bradshaw v. SAIF*, 69 Or App 587, 589 (1984) (causation not logically inferred from temporal sequence unless all other explanations excluded); *Scott W. Wilson*, 50 Van Natta 1096, 1097 (1998) (Claimant's causation opinion not reliable because he is not a medical expert).

[4] *See Bacilio Valedez*, 49 Van Natta 1962, 1963 (1997) (distinguishing *Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988), because causation opinion not dependent on surgical observations).

January 22, 1999 Cite as 51 Van Natta 115 (1999)

In the Matter of the Compensation of
ROBERT J. GENTRY, Claimant
WCB Case No. 98-00928
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's denial of claimant's right knee injury claim. On review, the issue is compensability.

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

On review, claimant contests the ALJ's finding that the more persuasive witnesses were those who testified that claimant exhibited right knee symptoms, such as limping, before claimant twisted his knee at work. According to claimant, if we find that claimant was asymptomatic before the injury, he proved compensability.

Even if we assume that claimant was asymptomatic before the injury, he did not carry his burden of proof. Based on the ALJ's reasoning, we agree that claimant has a preexisting condition and that he must prove compensability under ORS 656.005(7)(a)(B). Claimant's treating physician, Dr. Tesar, indicated that, if claimant was asymptomatic and did not have an immediate onset of symptoms at the time of the work event, the right knee tear was "degenerative." (Ex. 19-12, -13, -17). Based on such a history, Dr. Tesar thought that the preexisting condition was the major contributing cause of the need for treatment and disability of the "combined condition." (*Id.* at 15, 21).

In sum, based on Dr. Tesar's opinion, claimant failed to proved compensability.

ORDER

The ALJ's order dated August 31, 1998 is affirmed.

January 22, 1999 Cite as 51 Van Natta 116 (1999)

In the Matter of the Compensation of
JACKIE T. GANER, Claimant
WCB Case No. 97-09610
ORDER ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

On November 12, 1998, we issued an Order on Review that reversed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's consequential mental disorder claim. Contending that we based our order on incorrect findings of fact and applied the incorrect law, claimant sought reconsideration and reinstatement of the ALJ's order.

In order to further consider the matter and to grant the employer an opportunity to respond, we abated our order. Having received the employer's response and claimant's reply, we proceed with our reconsideration.

We begin by addressing claimant's contentions on reconsideration that specific findings of fact were in error, and then we consider the proper law to be applied to determine whether a "consequential" mental condition is compensable.

Claimant first argues that our finding that her May 1995 hysterectomy resulted in complications and a nine-week absence from work is not supported by the evidence, particularly in light of the history claimant provided to Dr. Rohrer, neurosurgeon, who evaluated her low back condition on October 5, 1995.[1] (Ex. 4). Our finding is supported by Exhibit 3, Dr. Rich's September 29, 1995 chart note, which reports that claimant experienced a hysterectomy and oophorectomy and had "probs healing--took 9 weeks to return;" and Exhibit 17, Dr. Rich's September 25, 1996 chart note, which also reports that particular history in somewhat more detail.[2]

The second paragraph in our findings of fact regarding the circumstances of claimant's low back injury is supported by Exhibits 2, 3 and 4. Claimant's low back injury and change to light duty work is supported by Exhibit 3-1. The sixth paragraph containing a finding that claimant reinjured her back in the work hardening program is supported by Exhibits 18-1, 21-2 and 29-3.

Claimant also objects to our "interpretation" of Dr. Rich's chart notes concerning claimant's brother-in-law being a "father figure" (Ex. 3), suggesting that, in the absence of further explanation or cross-examination, the finding is improper.

Dr. Rich's September 29, 1995, chart note stated that claimant's "bro-in-law died 8/26/95 in Tenn." The note also stated, "[F]ather figure for Jackie-m. to older sister." Whether the "father figure" was a statement by claimant or an evaluation by Dr. Rich, the information in the chart note was supported by the testimony of the employer's representative that claimant apologized to her in January

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[1] Dr. Rohrer reported that claimant "states that approximately nine weeks ago she underwent a vaginal hysterectomy and did well post-operatively up until 8/7/95 when she hurt her lower back when transferring a patient at work." (Ex. 4-1). Because Dr. Rich was treating claimant's depression, unlike Dr. Rohrer, who was evaluating claimant's physical condition, we find the history reported by Dr. Rich more reliable in regard to claimant's claim for a mental disorder.

[2] Dr. Rich reported: "Put off past surgery a long time blood, infection not heal well 9 week absence" (Emphasis in original).

1996 for her emotional state and stated that family members had recently died. (Tr. II-50, 51). These references, taken together, (*i.e.*, that there were off-work stressors regardless of whether claimant's brother-in-law was a "father-figure"), support our conclusion that work was not the major cause of claimant's mental condition.

We next turn to claimant's assertion that we applied the incorrect law to this case. Specifically, claimant contends that *Boeing Co. v. Viltrakis*, 112 Or App 396 (1992), and *Aetna Casualty Co. v. Robinson*, 115 Or App 154 (1992), which address the compensability of a "consequential" mental disorder, rather than *Fuls v. SAIF*, 321 Or 151 (1995), which addresses the compensability of an initial claim for a psychological condition, govern this case.

In *Viltrakis*, the claimant compensably injured his knee. The claimant's doctor permanently restricted him from working more than 8 hours per day, 5 days per week. Later, the claimant filed a claim seeking benefits for treatment of the effects of stress allegedly caused by his fear that he would be laid off because of his inability to work overtime because of the knee injury. The employer denied the claim.

On appeal, the employer argued that the claimant's claim for the effects of stress was a claim for a mental disorder under ORS 656.802. The court held that not all claims for a mental disorder must be brought as occupational disease claims under ORS 656.802. *Viltrakis*, 112 Or App at 398. The court explained that, if a claim for a mental disorder is brought as an *independent* claim, it must be brought under ORS 656.802 as a claim for an occupational disease. However, the *Viltrakis* court reasoned that, if the condition results from a compensable injury, it may be treated as a claim for the consequences of an injury:

> "[W]hen a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply." *Id.* at 399.

Similarly, in *Robinson*, the claimant suffered a compensable back injury when he slipped on ice in the company parking lot. Subsequently, the claimant was diagnosed with depression. The employer denied compensability for "mental disorder including all disability, symptoms and treatment in any way related thereto." The court, applying *Viltrakis*, concluded that the claimant was seeking compensation for a consequential mental condition and that the provisions of ORS 656.802 did not apply. The court explained that, regardless of whether the onset is gradual or sudden, a mental condition that results directly from work is treated as an independent claim governed by ORS 656.802 and a mental condition that results from a compensable injury is treated as a claim for the consequences of an injury.[3] *Robinson*, 115 Or App at 156, 157.

Unlike the claims presented in *Viltrakis* and *Robinson*, the claim filed in *Fuls* did not involve a "consequential" mental condition. In *Fuls*, the claimant had been greeted by a customer who grasped him in a "bear hug." This incident caused no physical problem, but led to a paralysis that was diagnosed as conversion reaction, a mental disorder. The Court of Appeals concluded that, because the claimant was seeking to establish the independent compensability of a mental disorder, his claim must be analyzed as an occupational disease claim under ORS 656.802.

On appeal before the Supreme Court, the issue was whether the claimant's condition should be analyzed as an injury, because it was sudden in onset, or as an occupational disease under ORS 656.802. The Court first established that ORS 656.802(1)(b) specifically includes "any mental disorder" within the definition of "occupational disease," without regard to the suddenness of its onset. The Court then established that the sole condition for which the claimant sought compensation was a mental disorder. Finally, the Court held that, because the sole condition for which the claimant sought compensation was a "mental disorder," his claim was not compensable, pursuant to the unambiguous terms of ORS 656.802(3), unless he satisfied paragraphs (a) through (d) of that subsection.

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[3] We note that the court did not apply ORS 656.005(7)(a)(A) in this case; however, it did note that the test was "major contributing cause" under the amended statute. *Robinson*, 115 Or App at 157, n 2.

We recognize that the Supreme Court is the higher appellate body. However, the Court's analysis in *Fuls* does not repudiate or call into question the Court of Appeals' analysis that relied on the distinction between a claim for a mental disorder as a consequential condition and one for its independent compensability. Moreover, although the Court stated in *Fuls* that ORS 656.802 applies to "any mental disorder," the Court was addressing the argument that claimant could prove a compensable mental disorder under an "injury" theory, rather than whether it applies to a claim for a "consequential" mental disorder.[4] Finally, the circumstances of *Fuls* support the proposition that the claimant's claim in that case was an independent claim, which, in turn, supports the *Viltrakis* rationale. Thus, the Court's decision in *Fuls* is not necessarily contrary to the rationale provided in *Viltrakis* and its progeny.[5]

In this case, in contrast to the circumstances in *Fuls*, claimant, who experienced a compensable low back injury, seeks benefits for a mental disorder--depression--allegedly caused by that compensable injury. As in *Viltrakis*, if the condition is compensable it is because it is related to the compensable injury, not because it is independently work-connected. Furthermore, pursuant to ORS 656.005(7)(a)(A),[6] a claimant must prove that the compensable injury is the major contributing cause of the consequential condition. *Robinson v. Nabisco, Inc.*, 143 Or App 59 (1996), *rev allowed* 325 Or 247 (1997) (legislature amended ORS 656.005(7)(a)(A) in 1990 to require that, in order for an injury or disease to be compensable as a "consequence" of a compensable injury, it must be proven that the compensable injury is the major contributing cause of the consequential condition); *Albany General Hospital v. Gasperino*, 113 Or App 411, 415 (1992) (major contributing cause test applies to a condition or need for treatment caused in turn by the compensable injury).

Having determined the appropriate legal standard, we proceed to an application of that analysis. For the same reasons discussed in our November 12, 1998 Order on Review, we continue to find that the claim is not compensable. In doing so, we find the opinions provided by Dr. Rich, Dr. Rodriguez and Dr. Wicher unpersuasive.

Claimant was injured in August 1995. She was diagnosed with depression in September 1995. In her September 1995 chart notes, Dr. Rich made no mention of claimant's low back injury. However, the chart notes provide medical evidence that claimant was experiencing off-work stressors at that time. In her September 1997 letter, Dr. Rich stated that, at her initial meeting, claimant had undergone changes in work and was feeling inadequate as a result. Dr. Rich also stated that, when claimant returned to treatment in September 1996, she had been terminated from employment and was experiencing physical problems and marital difficulties. Claimant was not treated by Dr. Rich after September 1996.

In a 1998 report, Dr. Rich elaborated on her earlier report, stating that when claimant returned in 1996, she was focused on work-related concerns, physical problems and interpersonal relationship issues. Rich reported that, in 1996, claimant appeared to have suffered a significant loss of self-esteem

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[4] We note that there has been no "consequential" mental disorder claim case issued by the Court of Appeals subsequent to *Fuls*.

[5] Because our rationale on reconsideration is contrary to the rationale applied in *Susan M. Ables*, 50 Van Natta 833 (1998), in which we applied ORS 656.802 to a "consequential" mental disorder claim, we disavow our reasoning in that case.

[6] ORS 656.005(7)(a)(A) was amended in 1990 and now provides:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

caused by her injury-related job loss.[7] However, Dr. Rich did not state that the major contributing cause of claimant's depression was her low back injury, nor did she evaluate the relative contributions of the injury and the off-work stressors to claimant's depression. *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).

Dr. Rodriguez, who began treating claimant in April 1996 for heart palpitations, also diagnosed depression, for which he prescribed anti-depressant medication. In a September 18, 1996 chart note, Dr. Rodriguez attributed claimant's depression to "chronic low back pain." However, he based his conclusion that claimant's work injury was the major contributing cause of her depression on studies showing a correlation between chronic pain and depression, even when the cause is undetermined. Moreover, he did not note chronic back pain until September 1996, more than a year after claimant's injury, and failed to analyze claimant's individual circumstances in relation to the onset of her depression.

Finally, Dr. Wicher's opinion is unexplained and conclusory, and nothing in the medical record indicates whether Wicher was aware of the other problems claimant had been experiencing at the time of her 1995 injury.

In the absence of persuasive medical opinion that claimant's low back injury was the major contributing cause of her depression, we continue to find that her consequential mental disorder is not compensable.

On reconsideration, as supplemented and modified herein, we republish our November 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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[7] We acknowledge that job loss resulting in loss of self-esteem due to a compensable injury can be considered under a "consequential" condition theory. *See generally SAIF v. Freeman*, 130 Or App (1994), *Cheryl A. Trask*, 47 Van Natta 322 (1995). However, Dr. Rich did not discuss the contribution from off-work interpersonal relationship issues in relation to claimant's loss of self-esteem, as required under *Dietz*.

In the Matter of the Compensation of
HEATHER J. JACKLEY, Claimant
WCB Case No. 98-04223
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order that declined to award additional temporary partial disability (TPD) during the period from January 7, 1998 to March 10, 1998. In its brief, the insurer moves to: (1) dismiss claimant's request for review on the ground that it was improperly filed; and (2) strike claimant's appellant's brief on the ground that it was untimely filed. On review, the issues are temporary disability, motion to dismiss, and motion to strike.

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

Motion to Dismiss

The insurer moves to dismiss claimant's request for review because it was filed by a legal assistant rather than claimant's attorney. Because the legal assistant is not an attorney, the insurer argues that the request for review is a nullity.

In response, claimant has submitted an affidavit from the legal assistant who avers that claimant's attorney specifically directed her to appeal the ALJ's order and that she filed the request for review under the direction and control of claimant's attorney. Considering the content of the unrebutted affidavit, as well as the fact that the request for review was made on claimant's attorney's letterhead, we are persuaded that the legal assistant acted under the direction and control of the attorney. Therefore, we find that the request for review was valid. Accordingly, we deny the motion to dismiss.

Motion to Strike

Claimant's respondent's brief was due on November 13, 1998. The insurer received its copy of claimant's brief on November 17, 1998. Noting that the accompanying envelope was postmarked November 16, 1998, the insurer asserts that claimant's respondent's brief was untimely served and should not be considered on review. We disagree.

Claimant hand-delivered the appellant's brief to the Board on November 13, 1998, the due date. Thus, the brief was timely filed with the Board. Granted, service was not timely made on the insurer. According to the legal assistant's affidavit, the brief was ready to be mailed on the due date, but, because of "miscommunication," it was not mailed until the next business day. There was, however, no prejudice to the insurer, because it was able to respond to claimant's brief in accordance with the briefing schedule. Under these circumstances, we decline to strike claimant's respondent's brief. *See David F. Weich*, 39 Van Natta 468 (1987) (motion to strike brief denied where no prejudice resulted from the claimant's failure to fully comply with briefing procedures).

Temporary Disability

The insurer calculated claimant's TPD during the period from January 7 to March 10, 1998 based on a four-hour work day. The ALJ determined that the four-hour TPD rate was appropriate. We supplement the ALJ's order to respond to claimant's contention that the attending physician, Dr. Reilly, never approved of the modified job and, thus, that the insurer improperly paid TPD based on a four-hour work day.

On December 19, 1997, Dr. Reilly was sent a job description for a light duty position entitled "Clerical-Reception Phone Triage." (Ex. 4A-2). Dr. Reilly stated that duty was acceptable, but that claimant could not sit or stand over four hours. Dr. Reilly stated that claimant would be reevaluated on December 29, 1997. *Id.*

Dr. Reilly saw claimant once more and, on December 30, 1997, released claimant to work four hours per day in the "Light Duty, Clerical Reception Phone Triage" position. (Ex. 6). Although claimant never worked four hours per day, testifying that the light duty work exceeded her physical limitations, Dr. Reilly would not reduce her work hours, although requested by claimant to do so. (Tr. 24).

We reject claimant's request that she receive TPD based on the hours she actually worked. Dr. Reilly received a copy of claimant's job description. (Ex. 4A-2). Although he did not indicate his approval on that form, he later approved claimant for a four-hour work day, referring to the "Clerical Reception Phone Triage" position. (Ex. 6). Claimant returned to work in the modified job. While she voluntarily limited her hours to less than four per day, the medical evidence does not support claimant's contention that her modified job exceeded her limitations given Dr. Reilly's refusal to reduce her hours.

Under these circumstances, we find that claimant's TPD rate was correctly based on a four-hour day. Accordingly, we affirm.

ORDER

The ALJ's order dated September 23, 1998 is affirmed.

In the Matter of the Compensation of
LOUIS SZABO, Claimant
WCB Case No. 98-03962
ORDER ON REVIEW
Bottini, Bottini, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of his occupational disease claim for bilateral hearing loss. On review, the issues are timeliness of claim filing, and compensability. We affirm.

FINDINGS OF FACT

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

A colloquoy between claimant's attorney and claimant at hearing was as follows:

Q. Claimant, when you were getting tested for your ears at this time, did any of the physicians or anyone testing you tell you that you had hearing loss attributable to noise?

A. Yes. As a matter of fact, the doctor the insurance company send me to -- I don't remember his name -- his assistant -- she told me it was a typical noise-related hearing loss.

Q. What physician was that?

A. I don't remember the doctors anymore. The insurance company sent me a letter sending me to this doctor to have my hearing tested.

Q. Dr. Hodgson?

A. It could be. I don't know his name. It's on the records. I don't remember his name.

Q. Before that time had any of the examiners told you that you had --

A. Yes. I had it done on my own -- on my own expense. A year and a half ago I went to a specialist because I though maybe I have physical problems -- something happening in my ears, physical changes or something, maybe require surgery or my ears full of wax or something. So I went to a specialist, and he examined my ear, and he said there's nothing wrong with my ear; I have typical noise-related hearing loss. I think the work used was bilateral or some similar thing.

Q. When you got your hearing tested at Gunderson * * * .

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial on the basis that claimant's claim was untimely filed and on claimant's failure to prove compensability. On review, claimant contends that he filed his claim timely and that he has established compensability.

Untimely Claim Filing

Claimant contends that his claim should not be barred because he filed his claim within the time frame required by ORS 656.807(1)(a). According to claimant, he was not informed by a physician that his hearing loss arose from his employment until he was examined on July 9, 1997 by Dr. Kaplan. Because he filed his claim against the insurer on March 6, 1998, he argues that he satisfied the one-year time limit in ORS 656.807(1). The insurer contends that claimant's claim is void because he was aware of the existence of an occupational disease involving hearing loss between 1975 and 1991, and that his disability was apparent no later than three years prior to the date of hearing. We agree that claimant satisfied the statutory requirements of ORS 656.807(1)(a), which provides:

"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." (Emphasis added.)

The latest date in this case is the date claimant was informed that he was suffering from an occupational disease, not the date he first discovered the occupational disease or the date he became disabled. In order for a physician to inform a claimant that he is suffering from an occupational disease under the statute, the physician must have told the claimant "'simply and directly' that his disease arose out of his employment." *Liberty Northwest Ins. Corp. v. Meeker*, 106 Or App 411, 414-15 (1991); *Jon O. Norstadt*, 48 Van Natta 253 (1996).

Here, although claimant was informed by a specialist that he had bilateral noise-related hearing loss about a year and a half prior to the August 19, 1998 hearing, *i.e.*, about February 1997, (Tr. 21, 22), there is no evidence that this specialist told claimant "simply and directly" that his hearing loss was caused by his employment. *See Ralph T. Masuzumi*, 45 Van Natta 361 (1993). The record establishes that claimant was not informed that his hearing loss arose from his employment until Dr. Kaplan so informed him in July 1997. (Ex. B). Consequently, we conclude that claimant's March 6, 1998 claim against the insurer was timely filed.

Compensability

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

On review, claimant contends that, in determining whether his hearing loss claim is related in major part to noise exposure at work, we should not weigh the relative contribution of presbycusis as a causative factor in relation to Mr. Fairchild's opinion. We have previously addressed this matter in *Henry F. Downs*, 48 Van Natta 2094, *on recon* 48 Van Natta 2199 (1996). Like the claimant in *Downs*, claimant's "disease" is his *entire* bilateral hearing loss. Therefore, in order to establish the compensability of the hearing loss as an occupational disease under ORS 656.802(2)(a), claimant must prove that "employment conditions were the major contributing cause of" his entire hearing loss. After our *de novo* review of the record, we agree with the ALJ's discussion of the medical evidence and her conclusion that there is a failure of proof.

ORDER

The ALJ's September 17, 1998 order is affirmed.

In the Matter of the Compensation of
CHRIS A. ATHA, Claimant
WCB Case No. 98-01848
ORDER ON REVIEW
Darris K. Rowell, 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) Kekauoha's order that awarded claimant's attorney an assessed fee of $3,000 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. On review, the issues are attorney fees and remand.

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

Attorney Fee

The ALJ awarded claimant's attorney an assessed fee of $3,000 for services at hearing. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to draw conclusions from those facts in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4).

We considered a similar 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 Supreme Court's entire decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make specific findings for each rule-based factor.

Here, the ALJ simply ordered SAIF to pay an assessed fee of $3,000. Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), we agree with SAIF that the ALJ's reasoning in arriving at the fee amount is not sufficient for our 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.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The primary issue at hearing was compensability of claimant's injury claim for chest and mid-back conditions. The record contains no statement of services documenting the time claimant's attorney spent on the case. The hearing transcript was 154 pages. Three witnesses, including claimant, testified on her behalf. Two witnesses testified on the employer's behalf. The record contains 17 exhibits, two of which were generated by claimant's attorney. There were no depositions.

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. Because claimant's chest and mid-back conditions have been found compensable, he is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, based on the conflicting medical evidence, there was a risk that claimant's counsel's efforts might have gone 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 claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated October 16, 1998 is affirmed.

January 22, 1999 Cite as 51 Van Natta 124 (1999)

In the Matter of the Compensation of
RONALD ERICKSON, Claimant
WCB Case No. 97-06895
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a penalty for allegedly unreasonable claims processing. On review, the issues are compensability and penalties. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

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

Claimant experienced a birdshot wound in the back approximately 15 years prior to the current injury. He experienced no leg pain as a result.

In December 1994, claimant sustained a low back injury while lifting at a different employer. X-rays revealed significant degenerative changes in the spine, particularly at L5-S1. Claimant was declared medically stationary in regard to this injury on January 16, 1995.

On May 1, 1997, claimant experienced a low back incident as a result of lifting and twisting at the employer. He sought treatment at an emergency room, complaining of pain over the right low back that extended into the right thigh and knee. The emergency room doctor diagnosed sciatica. (Ex. 4). Dr. Turcot, claimant's family doctor, diagnosed sciatica and suspected a possible herniated disc and back sprain. (Exs. 6, 10). Dr. Hanson, chiropractor, found decreased range of motion in the low back and muscle spasm at the piriformis. He diagnosed lumbosacral facet sprain. (Ex. 7).

On May 23, 1997, Dr. Lewis, orthopedist, noted that x-rays revealed findings similar to earlier films, with significant degeneration of the spine with almost complete spondylosis at L5-S1. Lewis diagnosed preexisting degenerative changes with work-related aggravation causing mechanical low back pain and inflammation with mild sciatica. (Ex. 11).

On May 28, 1997, claimant reported constant pain on the right side of his low back, right hip and right lateral thigh, with numbness in the lateral right thigh to the knee. He also reported that, during the last two or three days, he had noticed pain in the right groin. (Exs. 12, 13). On June 13, 1997, claimant reported pain on the inside of the right thigh and bilateral leg pain. (Ex. 20).

An MRI revealed a small central disc protrusion at L4-5 with slight impression upon the thecal sac, mild bilateral neural foraminal narrowing at L5-S1 and on the right at L4-5, with multiple Schmorl's nodes present in the spine. (Exs. 23, 24).

On July 10, 1997, claimant complained to Dr. McNabb, physical medicine and rehabilitation, of right sided pain in the upper low back, radiating into the buttocks, anterior thigh and groin. McNabb ordered a bone scan and EMG. McNabb assessed the results of these tests as being most consistent with an obturator nerve injury. McNabb also noted an elevated sedimentation rate of 38. (Exs. 25, 26, 27, 28).

On July 30, 1997, Drs. Stanford and Bell examined claimant for the employer. (Ex. 29).

In November 1997, Dr. Gibbs performed a records review. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's May 1,1997 injury was the major contributing cause of both a facet strain and an obturator nerve injury in claimant's low back. On review, the employer argues that claimant has failed to prove compensability of either condition. We conclude that claimant has proven compensatility of the facet strain until July 30, 1997, but agree with the employer that the obturator nerve injury is not compensable, based on the following reasoning.

If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. ORS 656.005(7)(a)(B).

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed conditions (facet strain and obturator nerve injury) than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). In other words, the persuasive medical opinion must evaluate the relative contribution of different causes and explain why the compensable injury to claimant's low back contributed more to the claimed conditions than all other causes or exposures combined. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Furthermore, the fact that a work injury precipitated the symptoms of a condition does not necessarily mean that the injury was the major contributing cause of the condition. *Id.*; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Because of the preexisting degenerative low back condition and the manner in which the low back complaints developed, this claim presents a complex question of medical causation which requires expert medical evidence for its resolution. *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985); *Uris v. Compensation Department*, 247 Or 420, 424 (1967). We give greater weight to medical opinions that are well-reasoned and based on complete and accurate histories. *Somers v. SAIF*, 77 Or App 259 (1986).

We begin with the facet sprain with sciatica with which claimant was initially diagnosed. Dr. Hanson, chiropractor, who treated claimant's low back complaints in May 1997, opined that, even with claimant's "mild" arthritis at two different levels of the spine, the major contributing cause of his condition was his work activities. (Ex. 40-6). Hanson determined that the facet condition should have resolved within about four to six weeks. (Ex. 34).

Dr. Stanford, who evaluated claimant's injury for the employer on July 30, 1997, opined that claimant's injury combined with his degenerative change at L5-S1. Stanford explained that claimant may have strained his back on the job, but there was no acute episode, and absent the degenerative change, one would have expected the low back strain to have resolved by the date of the examination, July 30, 1997. (Ex. 29-6). Stanford also opined that, at this point, claimant's severe degenerative change was the major contributing cause for his disability and need for treatment. (*Id.*). Stanford's assessment that claimant suffered from severe degenerative arthritis was supported by that of Dr. Gibbs (Ex. 37), and Stanford's and Gibbs' assessment of the severity of claimant's preexisting condition is supported by other medical evidence in the record.

Based on Dr. Hanson's opinion, we conclude that claimant's work injury was the major contributing cause of claimant's facet sprain with sciatica. *Weiland v. SAIF*, 64 Or App 810 (1983) (we generally give special deference to the opinion of a treating physician, absent persuasive reasons to do otherwise). However, based on Dr. Stanford's persuasive opinion (which was supported by Dr. Hanson's expection that claimant's condition should have resolved within four to six weeks), we also conclude that the work injury no longer remained the major contributing cause of claimant's condition after July 30, 1997.

We next turn to the obturator nerve condition. The record includes relevant medical opinions concerning the cause of that condition from Dr. McNabb, specialist in physical medicine and rehabilitation; Dr. Lewis, claimant's treating orthopedist; Dr. Gibbs, neurologist; Dr. Stanford; and Dr. Hanson.

Dr. McNabb agreed that claimant had preexisting degenerative changes in his lumbar spine, which "may have been aggravated," but he opined that those changes were not the cause of claimant's current symptoms, particularly those "documentable by EMG and MRI," *i.e.*, the right obturator neuropathy. McNabb reasoned that the major contributing cause of the obturator nerve injury was the May 1, 1997 episode "since [claimant] did not complain of any groin pain and leg pain prior to that time." (Ex. 35).

Dr. Gibbs opined that claimant's obturator neuropathy had nothing to do with his lifting injury. He explained that, because the same nerve roots supply the obturator and femoral nerves, it would be impossible for a back injury to damage the obturator nerve without also damaging the femoral nerve, which did not happen in this case. He further explained that, in claimant's case, there were three possible causes of an obturator neuropathy, namely entrapment, the gunshot wounds, or mononeuritis (he reasoned that the elevated sedimentation rate may indicate a causative systemic condition).

Dr. McNabb responded that claimant's birdshot wound would not have affected the obturator region. McNabb admitted, however, that an obturator nerve hernia could be present causing entrapment and that claimant had an elevated sedimentation rate that he could not explain. McNabb again concluded that because claimant had no pain complaints prior to the injury and because the coincidence of an obturator nerve mononeuritis, a rare condition, at the same time as the injury would be extremely rare, that the cause was related to possible entrapment and/or hernia. (Ex. 38).

In his concurrence with McNabb's opinion, Dr. Lewis agreed that the gunshot wound had no effect on the obturator nerve injury, and agreed that a hernia, which could be trauma-induced, could be a cause. Basically, however, Dr. Lewis, like Dr. McNabb, relied most heavily on the temporal relationship between claimant's symptoms and his injury, opining that "one would have to presume until one could prove otherwise that the injury caused [claimant's] obturator nerve trauma."

Dr. Stanford, in reviewing claimant's history and based on his 32 years as an orthopedist, was unable to equate findings of an obturator nerve lesion with any injury claimant might have had. (Ex. 35). Finally, in his deposition, Dr. Hanson opined that an obturator nerve injury would be an unlikely diagnosis, based on claimant's injurious work activity and the complaints he presented to him, which were congruent with a facet strain with sciatica. (Ex. 40-7, -8, -9).

Although Dr. McNabb and Dr. Lewis identified claimant's May 1997 injury as the major cause of his obturator nerve condition and need for treatment, we are unpersuaded by their opinions, as they rely on the temporal relationship between claimant's work injury and the nerve condition.[1] Therefore, they are insufficient to outweigh the other expert opinions to the contrary, particularly in light of Dr. Gibbs' discussion of femoral nerve involvement, and Dr. McNabb's admission that he had no explanation for claimant's (possibly causative) elevated sedimentation rate. Finally, Dr. Lewis' opinion that the work injury may have involved a hernia that may have affected the obturator nerve is couched in terms of possibility rather than probability, which is not legally sufficient nor persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Consequently, we conclude that the medical evidence fails to establish that work is the major cause of claimant's obturator nerve condition.

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[1] For example, Dr. McNabb stated, "I am unsure on what and how he injured his right obturator nerve, but from history it seems that it is associated with his lifting injury." (Ex. 33-1).

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 employer denied the claim on the basis of all information, including Dr. Sanford's July 30, 1997 report, that the major contributing cause of claimant's "combined condition" was his preexisting degenerative arthritis in his low back. (Ex. 30). As noted above, the medical record amply established that claimant had severe degenerative arthritis in the low back, and Dr. Sanford's report attributed the major cause of claimant's condition at the time of his examination to the degenerative arthritis. Moreover, although Dr. McNabb diagnosed claimant with an obturator nerve injury on July 23, 1997, the date stamp indicates that the information was not received by the employer until August 8, 1997. (Ex. 28-1). Therefore, in light of the medical evidence available to the employer, we find that its denial was not unreasonable. Consequently, claimant is not entitled to an award of penalties.

The ALJ awarded an attorney fee of $4,300 for setting aside the employer's denials of claimant's facet strain claim and obturator nerve injury claim. Because we have upheld the employer's denial of claimant's obturator nerve injury claim and upheld the employer's denial of claimant's facet strain after July 30, 1997, we reduce the attorney fee award at hearing. However, claimant's attorney is entitled to an assessed fee for services at hearing for prevailing on the "pre-July 30, 1997" facet strain denial and defending that decision on review. 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 fee for claimant's attorney's services at hearing and on review concerning the "pre-July 30, 1997" facet strain denial is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. 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 obturator nerve injury issue.

ORDER

The ALJ's order dated August 7, 1998 is reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the employer's obturator nerve injury denial is reversed. That denial is reinstated and upheld. The employer's denial is also reinstated and upheld insofar as it pertains to a denial of claimant's facet strain condition after July 30, 1997. That portion of the order that awarded a penalty is reversed. In lieu of the ALJ's $4,300 attorney fee award for services at hearing, claimant's attorney is awarded $3,500 for services at hearing and on review, to be paid by the employer.

In the Matter of the Compensation of
RONALD CLARK, Claimant
Own Motion No. 93-0660M
OWN MOTION ORDER OF ABATEMENT
Hollander, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 16, 1998 Own Motion Order, which affirmed the SAIF Corporation's October 9, 1998 Notice of Closure in its entirety. Accordingly, we withdraw our December 16, 1998 order. SAIF is granted an opportunity to be respond. To be considered, that response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
R. K. LOCK, Claimant
WCB Case No. 97-10024
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) set aside its denial of claimant's injury claim for a right shoulder condition; and (2) awarded claimant's attorney an assessed fee of $3,000 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. On review, the issues are compensability, remand and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's August 14, 1997 injury combined with a preexisting right shoulder problem, *i.e.*, a type II acromion. The ALJ relied on Dr. Wells' opinion to conclude that claimant's August 14, 1997 injury was the major contributing cause of the need for treatment.

SAIF argues that Dr. Wells' opinion does not establish that claimant's work injury was the major contributing cause of the need for treatment. For the following reasons, we agree with SAIF.

Claimant acknowledges that ORS 656.005(7)(a)(B) applies to this case. Dr. Wells, claimant's treating physician, reported that claimant had a type II acromion and he explained that it was a congenital variation of the acromial structure, which tended to predispose to subacromial bursitis. (Exs. 8, 12). He agreed that claimant's August 14, 1997 injury combined with the preexisting condition to cause or prolong disability or need for treatment. (Exs. 10-2, 12).

Based on Dr. Wells' opinion, we agree with the ALJ that claimant had a preexisting type II acromion that combined with the August 1997 injury to cause or prolong her disability or need for treatment. Consequently, claimant must prove that her August 14, 1997 work injury was the major contributing cause of the disability or need for medical treatment for the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (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.*

Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. *Somers v. SAIF*, 77 Or App 259 (1986).

Claimant relies on the opinion of Dr. Wells to establish compensability. Dr. Wells diagnosed subacromial impingement and bursitis and he felt that claimant would probably need surgery. (Exs. 8, 19-6, -10). On October 31, 1997, Dr. Wells reported that claimant became symptomatic only after the work injury and "as a consequence, the injury would have to be the predominant cause for the need for medical treatment." (Ex. 12-1). On November 9, 1997, Dr. Wells agreed that he was unable to determine the major contributing cause of claimant's combined condition. (Ex. 13).

In a deposition, Dr. Wells testified that claimant's work incident was the major cause of the need for medical treatment. (Ex. 19-9). When asked the major cause of claimant's need for surgery, however, Dr. Wells replied:

"This is a difficult thing to say. Again, it comes under the head of the straw that broke the camel's back. It's certainly the incident that led to a series of events requiring medical intervention. The argument is or the question is, is the incident the cause or is it the preexisting configuration of the acromion that predisposes to it that caused it, and I don't know. I can't answer that. It varies from individual to individual." (Ex. 19-10).

Dr. Wells agreed that the August 1997 incident "certainly was initiating injury," but he would not determine a percentage of the contribution from the injury as compared to the preexisting condition. (Ex. 19-11). Dr. Wells explained that claimant had a type II acromion, which had a downward hook or curve, and he said that type of configuration tended to be associated with a higher incidence of subacromial impingement. (Ex. 19-8). He said that, with people who have a type II or III acromion, he could initiate subacromial bursitis and impingement in probably 90 percent of those people by requiring them to perform certain activities. (Ex. 19-14). Dr. Wells said that merely proved that he could take a vulnerable individual and force them to become symptomatic. (*Id.*) When asked to determine major contributing cause, he explained: "It's difficult for me to say because I can't properly weigh the importance of the preexisting portion of it with the initiating symptom." (*Id.*)

Although isolated parts of Dr. Wells' opinion might support claimant's position, when read as a whole, his opinion is not sufficient to establish compensability. At most, Dr. Wells opined that the work incident precipitated claimant's need for treatment for her right shoulder condition. The "precipitating" or immediate cause of an injury is not necessarily the "major contributing cause." *Dietz v. Ramuda*, 130 Or App at 401. Dr. Wells expressly refused to weigh the relative contribution from claimant's preexisting type II acromion and the work incident. (Exs. 13, 19-10, -14). We acknowledge that no incantation of "magic words" or statutory language is required to establish the compensability of a claim, provided the opinion otherwise meets the appropriate legal standard. *See Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). Nevertheless, Dr. Wells did not evaluate the relative contribution of claimant's preexisting condition and the work injury to determine the major contributing cause of her need for treatment. Thus, Dr. Wells' causation opinion is unpersuasive because it did not meet the *Dietz* standard.

We conclude that Dr. Wells' opinion is insufficient to establish that claimant's August 1997 work injury was the major contributing cause of her need for treatment. Because no other medical opinion supports compensability of claimant's right shoulder condition, we find that she has failed to meet his burden of proof.[1]

ORDER

The ALJ's order dated September 1, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee is also reversed.

[1] In light of our conclusion, we need not address SAIF's argument that the ALJ failed to apply each of the factors in OAR 438-015-0010(4) and failed to make specific findings of fact as to each factor. In addition, it is not necessary to address SAIF's request that we remand the case to the ALJ to properly apply the factors in OAR 438-015-0010(4).

In the Matter of the Compensation of
LONNIE L. COLBRAY, SR., Claimant
WCB Case No. 98-03314
ORDER ON REVIEW
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Herman's order that affirmed the Order on Reconsideration that awarded no unscheduled permanent disability. On review, the issues are extent of unscheduled permanent disability and remand.

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

With his brief, claimant has submitted a report from a chiropractor which was not admitted into evidence at the hearing. Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's submission of the additional report 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 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.

Here, although the report from the chiropractor is dated after the hearing, claimant has not shown that a similar report was unobtainable with due diligence at the time of hearing. In addition, the report is not reasonably likely to affect the outcome of the case. Under such circumstances, we deny the motion for remand.[1]

ORDER

The ALJ's order dated September 1, 1998 is affirmed.

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[1] We note that the chiropractor report could not be considered regarding the extent of claimant's permanent disability in any case since it does not come from a medical arbiter or the attending physician at claim closure. *See* ORS 656.245(2)(b)(B); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994), *aff'd Liberty NW Insurance Corp. v. Koitzsch*, 155 Or 494 (1998) (with the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment). In addition, since the report is not part of the reconsideration record, it cannot be considered at hearing for purposes of making impairment findings. *See* ORS 656.268(7)(g); ORS 656.283(7).

In the Matter of the Compensation of
ROY FLORES, JR., Claimant
WCB Case No. 98-00758
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's right wrist injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that he injured his right wrist during an incident at work. In response to the employer's argument that claimant was not credible, the ALJ found that "the preponderance of evidence supports claimant's credibility as to the mechanism of injury and therefore compensability of his claim." On review, the employer continues to contest claimant's credibility and, based on inconsistencies in the record and testimony at hearing, asserts that claimant failed to prove compensability.

Claimant testified that, on November 14, 1997, while mounting a tire, the tire fell and hit a tire iron held by claimant; according to claimant, this event "jerked" and "snapped" his right wrist. (Tr. 9, 11). Claimant further stated that he felt immediate pain in his right wrist and, after reporting the incident to a coworker and his trainer, Clarence Allen, he told his immediate supervisor, Ron Bennett. (*Id.* at 12-13, 24-25). According to claimant, he then went to the nurses' station and obtained a wrist brace; after attempting to continue working, claimant returned to the nurses' station at Bennett's direction and was sent to the emergency room. (*Id.* at 13-14).

Clarence Allen stated that he noticed claimant wearing a wrist brace and asked him about it; according to Allen, claimant told him that he had "hurt" his wrist without mentioning a work incident. (*Id.* at 35).

Ron Bennett also testified that he noticed claimant wearing the wrist brace on November 13, the day before the purported injury. (*Id.* at 47). Bennett further stated that claimant spoke to him on November 14 about pain in his right wrist but did not report a work injury. (*Id.* at 48).

Jennifer Marple was a Certified Nurse's Assistant on duty during claimant's work shift. Marple corroborated that she saw claimant on two occasions on November 14. (*Id.* at 59). Marple testified that, when she saw claimant the second time, she asked him whether he had injured his wrist and he responded that "he wasn't sure what was going on." (*Id.*) Marple also denied that she supplied claimant with a wrist brace. (*Id.* at 60).

In response to such testimony, claimant again testified; this time, however, claimant stated that someone other than Marple gave him the wrist brace. (*Id.* at 75). Claimant's final testimony was that he obtained the wrist brace at the beginning of his shift, before the time of the purported injury. (*Id.* at 86).

Rosemary Rasmussen, a Registered Nurse who works day shift, then testified. Rasmussen denied seeing claimant on November 14 or giving him a wrist brace. (*Id.* at 19).

In evaluating the reliability of claimant's testimony, we first note that, because the ALJ relied on the "preponderance of evidence," his credibility finding was not based only on demeanor. Although we generally defer to the ALJ's credibility finding, 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).

Here, we find sufficient inconsistencies in the documentary and testimonial record to render claimant's credibility questionable. First, claimant did not consistently report the mechanism of injury. When claimant first went to the emergency room on November 14, he stated that he "was pulling on a tire bar * * * when he felt something snap in his right wrist." (Ex. 4-1). This version is different than his subsequent statement to medical providers, an investigator and at hearing that a tire fell on the tire bar, jerking his right wrist.

Claimant's testimony also was contradicted by Clarence Allen, Ron Bennett, Jennifer Marple and Rosemary Rasmussen. According to these witnesses, claimant never reported a job injury, nor obtained a wrist brace at work. The testimonies of Ron Bennett and Jennifer Marple are also consistent with written statement made at the time of, or shortly after, the purported work injury. (Exs. 1, 3A).

Finally, claimant's own testimony was contradictory. For instance, claimant first agreed that he had seen "the same nurse both times" on November 14. (Tr. 28). Later, claimant testified that, on his first visit to the nurses' station, he saw someone other than Jennifer Marple and that person gave him the wrist brace. (*Id.* at 76). Claimant then testified that he had no "clear recollection," again asserted that another nurse gave him the brace, and finally testified that he got the wrist brace before the alleged injury. (*Id.* at 83, 86).

We find that, at best, the evidence is in equipoise concerning the purported incident. Thus, we conclude that claimant did not carry his burden of proving, as a factual matter, that he injured his right wrist at work. Finally, after examining the medical records, we also find an absence of medical opinion

establishing that any work event caused the right wrist condition.[1] Consequently, we conclude that claimant also failed to prove medical causation.[2]

ORDER

The ALJ's order dated September 8, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

[1] Claimant does not contend that the facts of this case do not require expert medical opinion evidence. One of claimant's treating physicians, Dr. Ackerman, indicated that he could not differentiate claimant's swelling from an acute injury, as opposed to a chronic condition. (Ex. 19). Claimant's other treating physician, Dr. Buehler, indicated that claimant exhibited no "objective evidence of injury." (Ex. 20).

[2] Based on this conclusion, we find it unnecessary to address the employer's argument that the ALJ improperly denied its motion to dismiss or strike claimant's testimony because claimant did not attend the second day of hearing.

In the Matter of the Compensation of
JOY A. GREENE, Claimant
WCB Case No. 98-00468
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) found that claimant's left knee injury claim was not prematurely closed; and (2) reduced claimant's scheduled permanent disability award for loss of use or function of the left leg from 53 percent (79.5 degrees) as awarded by an Order on Reconsideration, to 51 percent (76.5 degrees). On review, the issues are premature closure and extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except that we do not find that Dr. Witczak concluded that claimant's inability to walk/stand (for a cumulative total of more than 2 hours in an 8 hour period) is due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's "Conclusions of Law and Opinion," with the following exception, modification, and supplementation.

Premature Closure

The insurer closed claimant's injury claim under OAR 436-030-0034(1),[1] because claimant had failed to seek medical treatment for more than thirty days. (*See* Exs. 51-2, 53-1). Claimant requested reconsideration, objecting to all aspects of the Notice of Closure. (Ex. 52). A medical arbiter was appointed.

[1] OAR 436-030-0034(1) provides in relevant part:

"A claim may be closed by the insurer or Department when the worker is not medically stationary and the worker has not sought medical care for a period in excess of 30 days, without the instruction or approval of the attending physician, for reasons within the worker's control. * * * "

See also OAR 436-030-0034(7).

The medical arbiter commented that claimant "may be considered medically stationary if she does not wish to have anything else done." (Ex. 55-3).

The Order on Reconsideration stated:

> "The worker has not sought medical care for over 30 days and has been sent a certified notification letter (7-18-97) concerning claim closure for not seeking medical care. See OAR 436-030-0034(7). The worker was last treated by Dr. Tidball on 5-27-97. The record shows the worker did not attend IME examinations scheduled for her on 5-09-97 and 6-12-97. However, 7-09-97, the insurer requested the Department suspend the worker's compensation benefits, which the Department's Sanctions Unit granted by Order dated 7-31-97. Benefits were suspended as of July 15, 1997. The worker was allowed 60 days from 7-31-97 Order to make an effort to reinstate her benefits. Prior to the conclusion of the 60 days, the insurer issued a Notice of Closure finding the claim statutorily qualified for claim closure per OAR 436-030-0034(1). The Appellate Unit finds the claim statutorily qualified for closure per ORS 656.268(1)(b). As a result, the claim closure of 8-07-97 was not premature. . . ." (Ex. 59-1-2).

The insurer requested a hearing, contending that the claim was prematurely closed or, alternatively, that claimant's scheduled permanent disability should be reduced to zero.

The ALJ found that the insurer's Notice of Closure was improper because its July 18, 1997 notification letter to claimant did not indicate that a copy of the letter was provided to Dr. Tidball, and therefore the closure did not strictly comply with OAR 436-030-0034(4).[2] Nonetheless, the ALJ found that closure was supported by claimant's failure to attend a reasonably scheduled IME, the Department's Order Suspending Benefits (pursuant to the insurer's request), and the subsequent passage of 60 days without evidence that claimant sought reinstatement of benefits. The ALJ reasoned that it was not necessary for the insurer to submit the claim to the Department for closure (based on claimant's failure to attend IMEs after the Suspension Order), because the claim was already closed by the August 7, 1997 Notice of Closure. Therefore, the ALJ concluded that the claim was not prematurely closed.

The insurer argues that the ALJ erred in finding the closure improper under OAR 436-030-0034, but upholding it under OAR 436-030-0095(11),[3] when the insurer did not submit the claim for closure under the latter rule. The insurer also contends that the parties "agree that claimant is not medically stationary." (Appellant's Brief, p. 8).

Claimant responds that the insurer may not now rely on the impropriety of its Notice of Closure, when it contended on reconsideration that "closure was not premature[]." (Ex. 53; *see* Ex. 58). Claimant also notes that the insurer did not challenge the medical arbiter's comment that claimant may be considered medically stationary "if she does not wish to have anything else done." (*See* Ex. 55-3).

We agree with the insurer that the claim was not closed based on claimant's failure to attend IMEs, so OAR 436-060-0095(11) does not apply. Accordingly, we do not adopt the ALJ's reasoning under that rule. But we note that the insurer did not challenge the Department's conclusion that the claim closure was *proper* under ORS 656.268(1)(b) (based on claimant's failure to seek medical treatment for

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[2] OAR 436-030-0043(4) provides: "The attending physician shall be copied on all notification and denial letters applicable to this rule."

[3] OAR 436-030-0095(11) allows a carrier to request that the Division close a claim, after suspension of benefits for failure to attend IMEs (under the rule), "If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent order [suspending benefits]."

more than 30 days)[4] at hearing or on review. We also note that claimant did not object to the propriety of the Notice of Closure under either rule or on any procedural ground.[5]

Under these circumstances, we agree with claimant that the insurer may not challenge its own Notice of Closure on procedural grounds (especially when claimant never objected to the administrative closure on procedural grounds). Consequently, we hold the insurer to the terms of its Notice of Closure: The claim was closed because claimant did not seek medical treatment for 30 days under OAR 436-030-0034(4). Finding no indication that claimant challenged the administrative basis for closure (or that she challenged the procedural validity of the closure under the rule), we agree with the Department that the Notice of Closure was valid. Finally, because the administrative closure was valid, we decline to consider whether claimant was *medically* stationary at claim closure. *See Tat Hueng*, 50 Van Natta 2205 (1998).

Extent of Scheduled Disability

We adopt the ALJ's opinion on this issue, except for the last two paragraphs, with the following supplementation and modification.

The ALJ found that claimant is prevented from walking or standing more than 2 hours in an 8 hour period based on the arbiter's opinion to that effect. The ALJ noted that the arbiter attributed this finding to continued knee pain (described as patellar pain), further noting that the arbiter went on to say that claimant's patellar pain is due to her accepted condition. (*See* Ex. 55-4).

We agree that this portion of the arbiter's report supports the ALJ's rating. But the arbiter previously opined that "some of" claimant's patellar pain and pain involving the patellar tendon is "due to her altered mechanics of ambulation and the increasing in the load bearing stresses on the amputated stump." (Ex. 55-3). Claimant's preexisting left leg amputation is not compensable. With that in mind we cannot say that the arbiter's qualified explanation, or his opinion as a whole, establishes that claimant's pain-related standing and walking restrictions are due to the accepted cellulitis condition.[6] Consequently, we conclude that claimant has not established entitlement to an impairment rating on this basis.[7]

Accordingly, claimant is entitled to a 42 percent impairment rating for reduced left leg range of motion. The ALJ's 51 percent award is modified.

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[4] ORS 656.268(1) provides in relevant part, that: "[c]laims shall not be closed if the worker's condition has not become medically stationary unless:

"* * * * *

"(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

[5] We disagree with the insurer's assertion that claimant agreed or stipulated *at hearing* that she was not medically stationary *at claim closure*. Claimant did raise premature closure on reconsideration, (*see Ex.* 56), but she asked the ALJ to affirm the Order on Reconsideration affirming the Notice of Closure and she asks us to do the same on review. Her April 14, 1998 written argument to the ALJ states that she "accepts the determination that she *is* not medically stationary." (Emphasis added to highlight claimant's reference to her then-current condition, not necessarily as it was in August 1997 at closure). Claimant's June 23, 1998 letter to the ALJ asks that the Order on Reconsideration be affirmed, noting that "[t]he claim can be reopened on the basis of aggravation." Thus, although claimant did raise "premature closure" on reconsideration, we find that her position at hearing was that she was not *then* (*i.e.*, at hearing) medically stationary, not that the claim had been prematurely closed.

[6] *See Todd M. Brodigan*, 45 Van Natta 438, 440 (1993), *aff'd mem* 128 Or App 59 (1994), *rev dismissed* 321 Or 98 (1995); *John R. Johanson*, 44 Van Natta 1511, 1512 (1992).

[7] We note that the ALJ concluded that the arbiter's opinion does not establish entitlement to a rating for limited ability to use the left knee. We agree, because the arbiter specifically stated, "This [limited ability, which claimant does have] is due to her [compensable] contusion *and* due to the preexisting below knee amputation." (Ex. 55-4, emphasis added).

Claimant's attorney is entitled to an assessed fee for services on review regarding the premature closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 5, 1998 is modified. In lieu of the ALJ's and Order on Reconsideration's scheduled permanent disability awards, claimant is awarded 42 percent (63 degrees) scheduled permanent disability for loss of use or function of the left leg. Claimant's out-of-compensation attorney fee award is modified accordingly. For services on review, claimant is awarded a $750 attorney fee, payable by the insurer.

In the Matter of the Compensation of
DARRELL A. MEYER, Claimant
WCB Case No. 98-02806
ORDER ON REVIEW
Bryant, Emerson, et al, Claimant Attorneys
Meyers, Radler, 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 denial of his current back, neck and shoulder conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on March 13, 1995 and was treated by Dr. Brennan. (Exs. 1, 2). The insurer accepted a nondisabling thoracic, trapezius and lumbar strain. (Ex. 4).

Claimant returned to Dr. Brennan on January 10, 1996, complaining that he had an acute exacerbation of back pain. (Ex. 5). He continued to see Dr. Brennan in 1996 and 1997. He was also treated by Dr. Kendrick, neurosurgeon.

On March 16, 1998, the insurer issued a denial of claimant's current condition, stating that his continued complaints and need for treatment was unrelated to the work injury and was due to preexisting degenerative disc and facet disease, and spondylolisthesis. (Ex. 37).

The ALJ found that, whether the standard was material or major contributing cause, the medical evidence did not establish a probable relationship between claimant's compensable injury and his current conditions.

On review, claimant relies on the opinions of Drs. Kendrick and Young, as well as Drs. Baum and Brennan, to argue that his current condition is primarily caused by his compensable injury.

Our first task is to identify the appropriate legal standards to determine the compensability of a worker's claim. *Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard v. Renalds*, 132 Or App 288 (1995)). Claimant agrees that expert medical evidence is necessary to decide causation. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

The medical evidence establishes that claimant has multilevel degenerative joint and disc disease that preexisted the March 1995 work injury. (Exs. 12-3, 28, 30, 32, 34, 36). Dr. Zivin concluded that claimant's preexisting cervical and lumbar degenerative conditions combined with his strain conditions to cause or prolong his disability or need for treatment. (Ex. 34-10). Dr. Brennan, claimant's treating physician, agreed with the substance of Dr. Zivin's report except for a minor historical change. (Ex. 36).

Dr. Young reported that claimant had preexisting multilevel degenerative joint and disc disease, as well as thoracolumbar Scheuermann's disease. (Ex. 28-3). He noted that claimant's March 1995 did not "aggravate materially or pathologically the pre-existing condition." (Ex. 28-5). Although Dr. Young did not believe the work injury had "materially aggravated" the preexisting degenerative condition, he did not comment whether or not the preexisting condition combined to some extent with the work injury to cause or prolong claimant's disability or need for treatment. We are persuaded by the reports from Drs. Zivin and Brennan that claimant's preexisting cervical and lumbar degenerative conditions combined with the work injury to cause or prolong his disability or need for treatment. Therefore, under ORS 656.005(7)(a)(B), claimant must establish that the March 1995 compensable injury is the major contributing cause of the disability or need for treatment of the current combined condition.

In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). 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).

Claimant relies on the opinion of Dr. Kendrick, among others, to establish compensability. On March 15, 1996, Dr. Kendrick reported that if claimant had no treatment between the March 1995 injury and January 1996, "it becomes harder to explain the relationship to the March, 1995 incident." (Ex. 11). There is no evidence in the record that claimant sought medical treatment for his accepted conditions between April 3, 1995 and January 10, 1996. In a later report on December 18, 1997, Dr. Kendrick opined that, although claimant had preexisting degenerative changes in the lumbar spine, they were asymptomatic before the March 1995 injury and he felt claimant's symptoms and need for treatment were related to that injury. (Ex. 30).

In a later report, however, Dr. Kendrick wrote to the insurer that it was "difficult to ascertain the true etiology in this case." (Ex. 33). He explained:

> "His claim was accepted for a lumbar strain which is certainly inaccurate in the fact that he continues to be symptomatic from this injury. We concur with you that it is abnormal for a lumbar strain not to resolve over a two year history, but we do not feel his claim should continue to be that of a lumbar strain." (*Id.*)

We are not persuaded by Dr. Kendrick's opinion because it is not well-reasoned and lacks adequate explanation. In his March 15, 1996 report, Dr. Kendrick said it was hard to explain the connection between claimant's current treatment and the March 1995 incident if claimant did not seek treatment between March 1995 and January 1996. (Ex. 11). Nevertheless, in his December 18, 1997 report, Dr. Kendrick related claimant's current symptoms and need for treatment to the March 1995 incident. (Ex. 30). Dr. Kendrick did not explain why, if claimant did not seek treatment between April 1995 and January 1996, his current symptoms continued to be related to the work injury. Furthermore, Dr. Kendrick acknowledged in his later report that it was difficult to ascertain the true etiology of claimant's condition. (Ex. 33). Because Dr. Kendrick's opinion is inconsistent and lacks adequate explanation, it is not persuasive.

Claimant also relies on Dr. Young's opinion to establish compensability. Dr. Young performed a records review and reported that claimant had preexisting multilevel degenerative joint and disc disease, as well as thoracolumbar Scheuermann's disease. (Ex. 28-3). He felt that claimant's current symptoms were not related to the abnormalities on the imaging studies, but were "probably related to soft tissue injuries such as spasm or strain which have evolved into a chronic condition." (Ex. 28-5).

On the other hand, Drs. Brennan and Kendrick did not believe claimant's current condition was a soft tissue injury. Dr. Kendrick thought it was abnormal for a lumbar strain not to resolve in two years and he did not believe claimant's current condition was a lumbar strain. (Ex. 33). Although Dr. Brennan originally concurred with Dr. Young's opinion, she subsequently agreed with Dr. Zivin's report, which said that the major contributing cause of claimant's current condition was his preexisting degenerative condition. (Exs. 34-10, 36). In light of Dr. Brennan's inconsistent opinions, we are not

persuaded by her earlier concurrence with Dr. Young's opinion. Moreover, because Dr. Young performed only a record review and did not treat or examine claimant, we are not persuaded by his opinion that claimant's current condition was a soft tissue injury.

Dr. Brennan has treated claimant since the March 1995 injury. On March 10, 1996, Dr. Brennan reported that claimant's March 1995 injury caused claimant to seek medical care initially and was the cause of his intermittent back discomfort since that time. (Ex. 10-2). Dr. Brennan's later reports on causation, however, are, at best, inconsistent and contradictory. As we discussed, Dr. Brennan concurred with Dr. Young's report, which said claimant's current condition was related to a soft tissue injury. (Ex. 32). In a later report, however, Dr. Brennan agreed with the substance of Dr. Zivin's report, which indicated that the major contributing cause of claimant's current condition was his preexisting degenerative condition. (Exs. 34-10, 36). Because Dr. Brennan did not explain her apparent change of opinion regarding causation of claimant's current conditions, we do not find her opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Furthermore, in light of Dr. Brennan's agreement with Dr. Zivin's report, we are not persuaded by her earlier opinion that the March 1995 injury was causing claimant's current condition. Dr. Brennan's opinion does not support compensability of claimant's current condition.

Claimant asserts that Dr. Baum's opinion supports compensability. On August 20, 1996, Dr. Baum examined claimant at the request of the Director. (Exs. 12, 13). He felt that claimant's current upper and low back pain was "predominantly related to degenerative disc disease which likely predated this injury but was asymptomatic." (Ex. 12-3). He noted that claimant's degenerative disease had been symptomatic since the March 1995 injury and would likely continue to be symptomatic. (*Id.*) Although Dr. Baum indicated that claimant's work injury caused the degenerative disc disease to be symptomatic, his opinion does not support claimant's argument that the work injury is the major contributing cause of disability or need for treatment of his current combined condition.

In sum, we conclude that claimant has failed to sustain his burden of proving compensability of his current cervical and lumbar conditions.

ORDER

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

January 25, 1999 Cite as 51 Van Natta 137 (1999)

In the Matter of the Compensation of
DARLENE J. MOLENA, Claimant
WCB Case No. 97-08181
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Scott Terrall, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's pulmonary condition. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order.[2]

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

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[1] The employer seeks reconsideration of our administrative decision that rejected its appellant's brief as untimely. Based on the uncontested representations contained in the employer's request, the brief has been considered during our review.

[2] We modify the ALJ's order to note that Exhibits 36A and 36B were admitted in evidence. (Tr. 1).

ORDER

The ALJ's order dated July 10, 1998, as reconsidered August 14, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
ROBERT E. MORRIS, Claimant
Own Motion No. 98-0429M
OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING
Ransom & Gilbertson, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a "Carrier's Own Motion Recommendation" form in which it recommends denying reopening of "claimant's "own motion" claim for a bilateral elbow epicondylitis condition. The insurer bases its recommendation solely on its contention that no surgery or hospitalization has been requested for claimant's compensable condition.[1] Claimant responds that his claim is not within the Board's own motion jurisdiction because his aggravation rights have not expired.

The filing requirements of ORS 656.273 are jurisdictional. *SM Motor Co. v. Mather*, 117 Or App 176 (1992); *Timothy D. Beard*, 43 Van Natta 432 (1991). Only if a claim for additional compensation is made outside the time limits of ORS 656.273 does it fall within the Board's own motion jurisdiction. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988); *Edward R. Reuter*, 42 Van Natta 19 (1990).

ORS 656.273(4) provides:

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268."

"(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

In *Donald G. Stacy*, 45 Van Natta 2360 (1993), *aff'd Stacy v. Corrections Division*, 131 Or App 610 (1994), we determined the "date of injury" for an initial occupational disease claim for purposes of determining aggravation rights for a *nondisabling* injury. See ORS 656.273(4)(b). In *Stacy*, we disavowed our holding in *Robert E. Wolford*, 45 Van Natta 435 (1993), which had held that in the case of an occupational disease claim, the "date of injury" for purposes of determining a claimant's aggravation rights is the date that the insurer accepts the occupational disease claim. Relying on *Papen v. Willamina Lumber Company*, 123 Or App 249 (1993), we held that, for the purposes of determining aggravation rights for *nondisabling* claims, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought.

On the other hand, if an occupational disease claim is originally accepted as *disabling*, the aggravation rights run five years after the date of the first closure of that claim under ORS 656.268. Under those circumstances, ORS 656.273(4)(b) does not apply, and the date of injury, as discussed in *Stacy*, is not determinative. Rather, under those circumstances, to determine the date by which an aggravation claim must be filed, we look to the date that claimant's claim was first closed. *See* ORS 656.273(4)(a); *Arlene J. Koitzsch*, 47 Van Natta 1293 (1995).

Here, Board staff requested the parties to provide their written positions regarding whether this claim is within the Board's own motion jurisdiction. Although the parties have responded with their positions and provided several additional documents, the record as currently developed presents several gaps regarding information necessary to determine the jurisdiction issue.

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[1] When a claim is within the Board's own motion jurisdiction, we may authorize 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.*

The limited record before us reveals the following. Claimant's left and right elbow epicondylitis conditions are occupational disease claims. On October 4, 1993, claimant was first treated for left elbow epicondylitis by Dr. Bowman. On August 8, 1994, claimant submitted an 801 form reporting an occupational disease involving the left and right arms and elbows. He described the cause of his left arm problem as repetitive motion during use of a microscope in his job as a cytologist. He indicated that he also noticed "some effect" in the right arm. He reported the "date of injury" as January 2, 1991.

On November 4, 1994, the insurer accepted a *right* elbow epicondylitis condition as *nondisabling*. We note that the record before us contains much evidence of medical treatment for claimant's *left* elbow epicondylitis condition, but no evidence of medical treatment for the *right* elbow epicondylitis condition.[2]

On November 20, 1995, the insurer issued a partial denial of claimant's "left elbow/arm condition." Claimant requested a hearing on that denial. The matter was settled by a March 21, 1996 Stipulation in which the insurer agreed to rescind its denial, accept the claim, and process it to closure.

On April 1, 1996, the insurer issued an acceptance of a "bilateral epichondylitis" [sic] condition. The insurer indicated that this was an "original injury," and classified it as "disabling" with a "date of injury" of January 2, 1991. We note that this appears to be the initial acceptance of the *left* elbow epicondylitis condition, although the *right* elbow condition was previously accepted on November 4, 1994.

On May 1, 1997, a Determination Order issued that awarded temporary disability from March 20, 1996 through March 5, 1997. Claimant requested reconsideration of that Determination Order. The record contains no evidence regarding the result of that request. Nevertheless, the record contains a copy of the insurer's August 25, 1997 request for a Determination Order that indicates the claim qualified for closure on August 1, 1997, and time loss was paid from March 20, 1996 through August 17, 1997. Thus, given the fact that the time loss dates on this subsequent request for claim closure include the dates of time loss on the May 1, 1997 Determination Order, it is possible that the May 1, 1997 Determination Order was set aside or vacated.

On September 10, 1997, a Determination Order issued that stated "the most recent medical information in our file indicated the worker is not medically stationary. Claim closure is premature." The record contains no evidence regarding any subsequent claim closure.

The next official action in the record is the insurer's October 20, 1998 "Carrier's Own Motion Recommendation" form, the document that brings this matter to our attention. In this recommendation the insurer recommends denying reopening in own motion claimant's occupational disease claim for a bilateral elbow epicondylitis condition. We note that the insurer failed to respond to requests for information on the recommendation form regarding the date claimant requested own motion relief. The insurer indicated that claimant's aggravation rights expired on January 2, 1996, five years from the January 2, 1991 "date of injury" indicated on claimant's August 8, 1994 801 form.

In addition, the insurer submitted a written statement, contending that claimant's claim was in own motion status at the time it became disabling on March 20, 1996. Although not entirely clear, the insurer appears to contend that the claim processing pursuant to the March 21, 1996 Stipulation was in error because the claim was within own motion status at that time. The insurer apparently bases this contention on its assumption that claimant's aggravation rights on both the right and left elbow epicondylitis conditions expired on January 2, 1996, five years from the January 2, 1991 "date of injury" indicated on claimant's August 8, 1994 801 form.

Claimant contends that his claim is not within own motion status. Furthermore, claimant advises us that he has requested a hearing before the Hearings Division, raising the following issues: back-up denial, unilateral termination of temporary total disability, unreasonable claims processing, failure to pay temporary total disability, penalties, and attorney fees. (WCB Case No. 98-09977).

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[2] Although an October 10, 1995 medical report by an unidentified author lists claimant's "chief complaint" as "severe left elbow pain, mild right elbow pain since about mid 1993," the body of that report only discusses the left elbow.

The record before us (as summarized above) remains inadequate to determine whether claimant's aggravation rights have expired on his occupational disease claims. In addition, this record raises several questions that involve the jurisdiction issue. For example, were there two separate occupational disease claims presented (one for the right elbow and one for the left elbow), resulting in two separate aggravation rights periods? Pursuant to ORS 656.273(4)(b) and *Stacy*, for the purposes of determining aggravation rights for *nondisabling* claims, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. Under that standard, when did aggravation rights run for the *right* elbow condition, which the insurer apparently accepted as a *nondisabling* condition on November 4, 1994? On this record, claimant apparently first sought medical treatment for a *left* elbow condition on October 4, 1993. But the insurer apparently first accepted the *left* elbow condition as *disabling* on April 1, 1996. If the *left* elbow condition is a separate occupational disease claim, the aggravation rights would run on that *disabling* claim five years after the date of the first closure of that claim under ORS 656.268. ORS 656.273(4)(a). Yet there is no evidence in the record when the *left* elbow claim was first closed under ORS 656.268. Any other question for which clarification may be helpful is whether claimant is currently seeking treatment for the left elbow condition, the right elbow condition, or both.

Given the many unanswered questions this undeveloped record presents, we are unable to determine whether claimant's claim is within our own motion jurisdiction. As litigation is pending regarding several issues involving this claim, we conclude that it would be in the best interest of the parties to consolidate this own motion matter with the pending litigation.

WCB Case No. 98-09977 is currently scheduled for hearing on March 25, 1999. At the hearing, the assigned Administrative Law Judge (ALJ) shall make findings of fact and conclusions of law and opinion on the issue of whether claimant's aggravation rights have expired on his occupational disease claim(s) so as to bring that claim(s) within the Board's own motion jurisdiction. The parties may want to consider the above questions regarding the jurisdiction issue when presenting this case to the ALJ.

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to the own motion matter and a copy of the appealable order issued in WCB Case No. 98-09977. After issuance of the order, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERROL L. SCHROCK, Claimant
Own Motion No. 98-0511M
OWN MOTION ORDER
Steven M. Schoenfeld, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable right shoulder strain, capsulitis, right cubital tunnel syndrome and ulnar compression neuropathy of the right elbow injury. Claimant's aggravation rights expired on January 21, 1998. The employer opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; and (2) surgery or hospitalization is not reasonable and necessary.

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

Here, the record submitted to us fails to demonstrate that claimant requires surgery or hospitalization for treatment[1]. As a result, we are not authorized to grant claimant's request to reopen the claim.

Accordingly, we deny the request for own motion relief. *Id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] With its recommendation, the insurer submitted a June 24, 1998 medical report from Dr. Puziss, claimant's treating physician, wherein it is noted that should manipulation and intra-articular cortisone injection prove ineffective, claimant may need to undergo further treatment in the form of an arthroscopy and possible decompression or capsulotomy. Should claimant's condition worsen to require said surgery, he may again request own motion relief. *See* ORS 656.278(1)(a).

In the Matter of the Compensation of
JANET P. SCULLY, Claimant
WCB Case Nos. 98-00470 & 97-06745
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Bock.

Liberty Northwest Insurance Company requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its responsibility denial for claimant's right upper extremity condition; and (2) upheld the SAIF Corporation's responsibility denial for the same condition. Claimant cross-requests review of those portions of the order that: (1) declined to award additional interim compensation payable by Liberty Northwest; (2) declined to award temporary disability benefits; and (3) declined to award interim compensation payable by SAIF. On review, the issues are responsibility, interim compensation, and temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and ultimate findings of fact, but substitute "right arm condition" for "bilateral wrist and right elbow conditions" in the first ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. In January 1995, claimant sustained a compensable occupational disease involving her right elbow and arm while working for Liberty Northwest's insured. Liberty Northwest accepted disabling tendonitis right elbow. The claim was closed with an award of temporary disability only.

In September 1995, claimant began working for SAIF's insured. On April 9, 1997, claimant sought treatment for her right arm from her attending physician, Dr. Bernard, who took her off work. (Ex. 16-2). On May 5, 1997, Dr. Bernard completed a form 2837 (Notice of Claim for Aggravation), authorizing time loss through May 12, 1997, noting that "[w]hen claimant returns to work she will need to limit gripping/manipulation repetitive movements with right hand or have frequent break periods." (Ex. 17). On May 12, 1997, Dr. Bernard authorized an additional four weeks of time loss (to June 9, 1997). On June 11, 1997, claimant returned for follow-up with Dr. Bernard. On August 14, 1997, Liberty denied compensability and responsibility.

On December 10, 1997, claimant filed a new occupational disease claim against SAIF's insured. In February 1998, Liberty conceded compensability but maintained its responsibility denial. SAIF denied only responsibility on March 11, 1998. On March 20, 1998, a ".307" order issued designating a paying agent.

The ALJ concluded that Liberty Northwest was responsible for claimant's current right arm condition and upheld SAIF's responsibility denial. The ALJ also concluded that claimant was entitled to interim compensation from May 5, 1997 to June 9, 1997, payable by Liberty Northwest, but was not entitled to temporary disability under the Liberty claim. Finally, the ALJ concluded that claimant was not entitled to any interim compensation from SAIF.

On review, Liberty Northwest contends that SAIF is responsible for claimant's current condition, and claimant contends that she is entitled to additional interim compensation from each carrier and temporary disability benefits payable by Liberty Northwest. We shall address each contention in order.

Responsibility

We adopt and affirm the ALJ's opinion on this issue, with the following modification of the last sentence to: "[Liberty Northwest] shall, therefore, remain responsible for claimant's current right arm and elbow condition."

Interim Compensation/Temporary Disability - Liberty

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

The ALJ awarded claimant temporary total disability, in the form of interim compensation, from May 5, 1997 through June 9, 1997, reasoning that Dr. Bernard's authorization of temporary total disability was for a date certain. On review, claimant contends that additional interim compensation[1] is payable by Liberty Northwest to October 16, 1997, the date it denied responsibility, and that temporary disability is payable through April 1, 1998.[2] We disagree.

A claimant's entitlement to interim compensation and temporary disability in an aggravation claim is contingent upon authorization for all periods of time by the attending physician. ORS 656.273(6); 656.262(4)(a) and (g);[3] *Mark V. Moser*, 50 Van Natta 221 (1998); *Gerald A. Zeller*, 48 Van Natta 501, *on recon* 48 Van Natta 735 (1996).

On May 5, 1996, Dr. Bernard specifically authorized claimant to be off work until May 12, 1997. (Ex. 17). On May 12, 1997, Dr. Bernard specifically indicated that claimant was unable to perform her regular duties for the next four weeks, and released claimant to modified work "if she can avoid using her right hand doing keyboard motions." (Ex. 18).

In contrast to these specific work releases, Dr. Bernard's June 11 and July 7, 1997, notes do not indicate that claimant was released from work or provide any specific time periods. (Exs. 20, 22). Inasmuch as Dr. Bernard had previously specifically authorized claimant's release from work, we are unwilling to conclude that the reports of claimant's off-work status made in those notes constitute an authorization for temporary disability benefits.[4]

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[1] The parties do not dispute the ALJ's interim compensation award.

[2] Interim compensation is paid upon receipt of notice of a claim until the claim is accepted or denied, while temporary disability is paid after acceptance of the claim. *See Jones v. Emanuel Hospital*, 280 Or 147 (1977). In this case, claimant requested the payment of interim compensation through October 16, 1997, the date that Liberty Northwest amended its denial to include responsibility. Even though the aggravation portion of the denial was withdrawn by Liberty Northwest in February 1998, the date of the initial denial was August 14, 1997.

[3] ORS 656.262(4)(g) (formerly numbered ORS 656.262(4)(f)) provides:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

[4] We contrast this case with *Daniel W. Garris*, 50 Van Natta 941 (1998), in which the attending physician filed an aggravation claim on the claimant's behalf and continued an off-work authorization, noting that time-loss was authorized from "11-6-96 thru present & continuing." We concluded that the aggravation form was the attending physician's last word on the claimant's ability to work prior to the denial, that the time loss authorization was open ended at the time of the denial and that the claimant, therefore, was entitled to temporary disability benefits.

Accordingly, we find that the May 12, 1997 chart note was Dr. Bernard's last word on claimant's ability to work prior to the August 14, 1997 denial. However, it is not clear to us whether he meant that claimant was released to modified work during the four-week period, or whether she was released to modified work following the four-week period. Because the chart note was equivocal, and because a carrier has no affirmative duty to infer authorization of temporary disability benefits from a medical report that does not clearly authorize such benefits, or to obtain verification of a worker's temporary disability status, *Moser*, 50 Van Natta at 222, we conclude that Dr. Bernard did not authorize temporary disability benefits beyond the four-week period.

Because ORS 656.262(4)(a) and (g) require specific authorization by the attending physician of procedural temporary disability, and because none was provided in this case beyond the four-week period after May 12, 1997, *i.e.*, June 9, 1997[5], we agree with the ALJ that claimant was not entitled to either interim compensation or temporary disability, payable by Liberty Northwest, after June 9, 1997.

Interim Compensation - SAIF

Claimant contends that she is entitled to interim compensation payable by SAIF from December 17, 1997, the date it received notice of the claim, through March 11, 1998, the date of its denial. We disagree.

Although a claimant is entitled to compensation for the period between the date of notice of his or her claim and the date of the insurer's denial, when, as here, the claim is properly denied, a claimant is not entitled to compensation between the date when he left work because of the injury to the date of the denial. *Spivey v. SAIF*, 79 Or App 568, 571 (1986). Accordingly, because Dr. Bernard's authorization of time loss applied to the date claimant left work because of the injury, and, as discussed above, the authorization ended as of June 9, 1997, claimant is not entitled to interim compensation from SAIF.

ORDER

The ALJ's order dated June 26, 1998 is affirmed.

[5] Assuming without deciding that Dr. Ellison became claimant's attending physician after the retirement of Dr. Bernard, there is no authorization of temporary disability in his notes. (Exs. 27, 30, 37).

January 25, 1999 Cite as 51 Van Natta 143 (1999)

In the Matter of the Compensation of
JOSEPY M. STRANSKY, Claimant
WCB Case No. 98-01087
ORDER ON REVIEW
Swanson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

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

FINDINGS OF FACT

On November 25, 1997, claimant, a driver, filed a claim for a left knee injury that allegedly occurred on November 21, 1997, while he and a coworker (Chavez) were delivering Sheetrock. Claimant alleged that he slipped and hit his knee on a step. (Ex. 3).

Claimant first sought treatment on November 23, 1997 from Dr. Schiller, an emergency room doctor, who diagnosed a fractured left patella of indeterminate age and contused/sprained left knee. On December 18, 1997, SAIF denied the claim, stating that there was insufficient evidence that the November 21, 1997 incident was the major contributing cause of claimant's left patella fracture and left knee sprain. (Ex. 6). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial, finding that claimant had failed to establish that he injured himself in the course and scope of employment. Moreover, to the extent that the medical evidence indicated that claimant sustained a work-related injury, the ALJ found that evidence unpersuasive because of an inaccurate history. Finally, because he upheld SAIF's denial, the ALJ rejected claimant's request for penalties based on an allegedly unreasonable denial.

On review, claimant contends that he sustained his burden of proving a compensable left knee injury and that, further, SAIF's denial was unreasonable. For the following reasons, we agree with claimant that he satisfied his burden of proving a compensable injury, but we do not agree that SAIF's denial was unreasonable.

Compensability

The ALJ cited several reasons for finding that claimant failed to satisfy his burden of proof. The ALJ first concluded that the medical record did not support claimant's testimony that he injured his knee. To the extent that the ALJ found that the claim was not supported by "objective findings," we conclude otherwise. *See* ORS 656.005(7)(a) (compensable injury must be established by medical evidence supported by "objective findings").

Dr. Schiller reported that claimant had tenderness in the left patella. (Ex. 2). In a subsequent examination on November 26, 1997, Dr. Davidson also noted that claimant had tenderness to direct palpation over the supralateral aspect of the patella. (Ex. 4). In a January 22, 1998 examination, Dr. Davidson continued to report tenderness on deep palpation. (Ex. 7). Because the finding of tenderness was reproducible on several occasions, we conclude that tenderness is an "objective finding" within the meaning of ORS 656.005(19). *See Marilyn M. Keener*, 49 Van Natta 110, 112 (1997) (finding "tenderness" to be an objective finding where reproducible). Therefore, we conclude that the injury claim was supported by objective findings of injury. ORS 656.005(7)(a).

The ALJ also cited claimant's delay in seeking treatment as a reason for upholding SAIF's denial. Claimant credibly testified, however, that he reported his injury to the employer, who encouraged him to delay seeking medical treatment in the hope that the condition would resolve over the weekend. (Tr. 6). Although the ALJ concluded that claimant's testimony was unsupported in the record, we note that the employer did not present any witnesses to rebut claimant's credible testimony. Under these circumstances, we find no reason not to accept claimant's credible testimony.

The ALJ, however, cited claimant's failure to produce the alleged witness (Chavez) to his injury and found that such failure cast distrust on his testimony. *See Roberts v. SAIF*, 18 Or App 590 (1974). There have been instances where we have viewed a claimant's testimony with distrust when there was a failure to call a corroborating witness. *E.g., Narciso Renteria*, 49 Van Natta 2176, 2177 n. 2 (1997) (because the claimant's injury was unwitnessed and because there was testimony contradicting portions of the claimant's testimony, it was crucial for the claimant to call the corroborating witness). However, we are not inclined to do so in this case given the absence of testimony contradicting claimant's testimony. *Cf. Rickey A. Stevens*, 49 Van Natta 1444 (1997) (failure to produce corroborating witness construed against the claimant where the employer provided countervailing testimony). Accordingly, we conclude that claimant's failure to produce Chavez as a witness is not fatal to the claim.

Based on our review of the record, we are unpersuaded by the ALJ's stated reasons for upholding SAIF's denial. SAIF, nevertheless, argues that a discrepancy between claimant's hearing testimony that he never previously injured his left knee and Dr. Schiller's history that claimant had fallen and struck his knee in the past casts doubt on the compensability of his claim. (Ex. 1). We disagree.

Claimant credibly testified that he told Dr. Schiller, in response to an inquiry about whether he previously hit his knee while participating in sports or similar activity, that he was sure he had, but that there had not been an instance significant enough to remember. (Tr. 7). Claimant further testified that he never previously experienced difficulties or restrictions with his knee. *Id.* We conclude that claimant's testimony reasonably explains any seeming discrepancy in the record regarding prior injuries.

SAIF also alleges that claimant has a preexisting condition that "could account for his symptoms," citing Dr. Davidson's and Dr. Fuller's diagnosis of a preexisting "tripartite patella." While Dr. Fuller, an examining physician, stated that the preexisting tripartite patella "combined" with the alleged knee injury, Dr. Fuller also opined that the left knee injury was the major contributing cause of the "combined condition." (Ex. 10-5). Therefore, even if we accepted Dr. Fuller's opinion that there was in fact a "combined condition" within the meaning of ORS 656.005(7)(a)(B), that condition would still be compensable.[1]

In summary, we find that claimant has met his burden of proving that he sustained a compensable left knee injury. Because the ALJ concluded otherwise, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Penalty

Claimant asserts that he is entitled to a penalty under ORS 656.262(11) for an allegedly unreasonable denial. We disagree.

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, SAIF denied the claim on the basis that there was insufficient evidence that the November 1997 work incident was the major contributing cause of claimant's left knee condition. We agree with SAIF that it had "legitimate doubt" regarding its liability for claimant's injury based on the delay in seeking medical treatment, the paucity of objective findings, the history of previous injuries contained in Dr. Schiller's emergency room report, and the presence of a preexisting condition. Accordingly, we conclude that no penalty is due under ORS 656.262(11)(a).

ORDER

The ALJ's order dated July 28, 1998 is reversed in part and affirmed in part. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

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[1] We note that the only other physician to address causation, Dr. Davidson, the attending physician, opined that claimant's work injury caused claimant's diagnosed contusion and need for treatment. (Ex. 11-1). He also stated that claimant's patella fracture was a direct consequence of the work injury. *Id.* Accordingly, we find that the medical evidence is unanimous in linking claimant's left knee condition to the work injury. Thus, we would find claimant's left knee injury claim compensable under either a material or major contributing cause standard.

In the Matter of the Compensation of
TERRY J. BOWERS, JR., Claimant
WCB Case No. 98-03571
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
James B. Northrop, 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 awarded a $3,000 assessed attorney fee. SAIF moves for remand to the ALJ. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand and affirm the ALJ's order with the following supplementary reasoning.

At hearing, the ALJ set aside SAIF's denial of claimant's right upper extremity condition and ordered SAIF to pay "a reasonable attorney fee pursuant to ORS 656.386(1) in the amount of $3,000[.]" Pursuant to ORS 656.386(1), claimant's attorney is entitled to a reasonable assessed fee for services provided at hearing in prevailing over a denial of a claim. In awarding an assessed fee under this provision, an ALJ "shall consider" the eight factors recited in OAR 438-015-0010(4).[1] Here, neither party submitted any argument to the ALJ as to how these factors should be weighed in determining a reasonable fee. And claimant's attorney did not submit a statement of services or make any specific attorney fee request regarding the services provided.

On review, SAIF moves to remand this case to the ALJ for further development of the record and findings of fact regarding the ALJ's attorney fee award. SAIF does not make any specific argument regarding the factors recited in OAR 438-015-0010(4) or otherwise argue that the $3,000 fee award is excessive. Instead, SAIF asserts that the record does not provide a sufficient basis for the Board's review of the ALJ's fee award, and SAIF contends that the ALJ's order is insufficient because he did not make findings of fact regarding each of the eight factors in the rule and demonstrate how these findings should be weighed in determining a reasonable attorney fee. SAIF relies on *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).

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). We found that the *McCarthy* 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. We further reasoned that this rationale applied to OAR 438-015-0010(4) because the statute considered by the Court in *McCarthy* included the same requirement that the reviewing body "shall consider" certain enumerated factors. Thus, 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 request, 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. *Accord Russell L. Martin*, 50 Van Natta 313 (1998) (where claimant did not make a specific fee request and neither party submitted a specific argument regarding the rule-based factors, the ALJ provided a sufficient rationale by stating that the factors recited in OAR 438-015-0010(4) were considered in determining the fee).[2]

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[1] OAR 438-015-0010(4) lists the following factors to be considered in determining a reasonable fee: the time devoted to the case; the complexity of the issue(s) involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured for the represented party; the risk in a particular case that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses.

[2] We found the *Martin* case distinguishable from *Schoch* because the claimant in *Martin* did not make a specific fee request, and neither party submitted a specific argument regarding the rule-based factors.

Here, as in *McCarthy, Underwood* and *Martin*, claimant's attorney did not submit a specific attorney fee request at hearing, and neither party submitted any argument to the ALJ as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, the ALJ would have satisfied OAR 438-015-0010(4) by citing that rule and noting that he had considered the rule-based factors. Instead, the ALJ did not include the requisite citation to the rule and simply ordered SAIF to pay "a reasonable attorney fee pursuant to ORS 656.386(1) in the amount of $3,000[.]" Nevertheless, remand is not warranted because the record is sufficiently developed to review the ALJ's attorney fee award, and we have the authority to modify or supplement the ALJ's findings and conclusions to include the citation to OAR 438-015-0010(4). ORS 656.295(5) and (6); *Underwood,* 50 Van Natta at 2332.[3]

To the extent any further rationale is required, we offer the following supplemental analysis based on the factors in OAR 438-015-0010(4).[4] We begin our analysis with the time devoted to the case as represented by the record.[5] In addition, we have particularly considered the complexity of the compensability issue, the value of the interest involved, the skill of counsel, and the risk that claimant's counsel might go uncompensated.

The documentary record is limited to 17 exhibits generated by SAIF, and the hearing was limited to opening and closing argument and testimony from claimant and his wife. Based on compensability disputes generally litigated before this forum, we find that this case presented factual, medical and legal issues of average complexity, and that the value of the interest and benefit secured is of average significance. Both attorneys are experienced litigators in the field of workers' compensation law. Considering the conflicting medical opinions and the potential standard of proof, there was a risk that claimant's attorney might go uncompensated. After considering these factors, we find that the ALJ's $3,000 fee is reasonable and should be affirmed.

Finally, we note that claimant is not entitled to an assessed fee for his attorney's services on review regarding the assessed fee issue. *See Dotson v. Bohemia Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 1, 1998 is affirmed.

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[3] Pursuant to ORS 656.295(5), we may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1983). Pursuant to ORS 656.295(6), the Board may affirm, reverse, modify or supplement the order of the ALJ and make such disposition of the case as it determines to be appropriate.

[4] As noted above, SAIF does not raise any argument on review based on a specific rule-based factor or otherwise argue that the ALJ's $3,000 fee award is excessive.

[5] As noted above, claimant's attorney has not submitted a statement of services rendered at hearing.

In the Matter of the Compensation of
CANDELARIO C. VIRGEN, Claimant
WCB Case Nos. 97-08598 & 97-08597
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that assessed a $4,000 attorney fee under ORS 656.386(1). On review, the issue is attorney fees.[1] *See Eva M. Smith*, 51 Van Natta 18 (1999).

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[1] We acknowledge SAIF's motion for remand "to take evidence and properly apply OAR 438-015-0010(4)." (Appellant's Brief, p.8). We deny the motion, because we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. *See* ORS 656.295(5).

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

The ALJ indicated that he applied the factors in OAR 438-015-0010(4) in determining claimant's attorney fee under ORS 656.386(1). The ALJ also explained how he weighed the rule-based factors to arrive at a reasonable fee. We agree with the ALJ's findings, reasoning, and conclusions on *de novo* review.

ORDER

The ALJ's order dated October 2, 1998 is affirmed.

January 26, 1999 Cite as 51 Van Natta 148 (1999)

In the Matter of the Compensation of
DOROTHY DICKINSON, Claimant
WCB Case No. 97-07047
SECOND ORDER ON RECONSIDERATION
Shelley K. Edling, Claimant Attorney
Scheminske, et al, Defense Attorneys

On January 13, 1999, we issued an Order on Reconsideration that adhered to our December 17, 1998 order that reduced claimant's assessed attorney fee from $9,500, as awarded by an Administrative Law Judge (ALJ), to $7,500. We have since received additional argument from claimant regarding the amount of the attorney fee awarded on review for services at the hearings level. Claimant also requests *en banc* reconsideration by the Board. We treat claimant's submissions as a motion for reconsideration of our January 13, 1999 Order on Reconsideration.

As a preliminary matter, we deny claimant's request for *en banc* reconsideration of this case. Although the Board may sit *en banc* in rendering a decision, it may also sit in panels. *See* ORS 656.718(3). When sitting in panels, a majority of the particular panel may issue the Board's decision. *Id.* Whether a case is reviewed *en banc* is a matter that the Board decides on its own motion.[1] Because this is not a case of first impression having a widespread impact on the workers' compensation system, and because it does not require disavowal of prior Board case law, claimant's request for *en banc* review is denied. *See Margaret S. Morgan*, 49 Van Natta 2072 (1997) (on recon); *Richard N. Wigert*, 46 Van Natta 756 (1994).

On the attorney fee issue, we reiterate that we have considered *all* the rule-based factors in evaluating the amount of the fee (including the risk that claimant's counsel may have gone uncompensated) and our fee award should *not* be interpreted as "setting an hourly fee."

Accordingly, we withdraw our prior orders for reconsideration. After reviewing claimant's contentions and reconsidering this matter, we adhere to the reasoning and conclusions reached in our January 13, 1999 Order on Reconsideration. Consequently, on reconsideration, as supplemented herein, we republish our January 13, 1999 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 the exercise of our *de novo* review, we select for *en banc* review those cases which raise issues of first impression that would have a widespread impact on the workers' compensation system or cases requiring disavowal of prior Board case law. This "significant case" review standard is applied to all cases before the Board.

In the Matter of the Compensation of
BARBARA A. HOOTEN, Claimant
WCB Case Nos. 97-08817 & 97-06102
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty's) compensability and responsibility denials of claimant's "new injury" claim for her current left shoulder and bilateral upper extremity conditions; and (2) upheld Grocers Insurance Group, Inc.'s (Grocers') aggravation and responsibility denials of claimant's aggravation claim for a neck condition. Grocers cross-requests review of that portion of the order that set aside its compensability and responsibility denials of claimant's right shoulder condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

We briefly summarize the relevant facts. In February 1994, claimant sustained a neck and right shoulder injury as a result of a lifting incident at Grocers' insured. Dr. Dandy diagnosed a cervical and right shoulder strain. Grocers accepted a disabling "right shoulder and cervical strain." (Ex. 6). The claim was closed by a November 7, 1994 Notice of Closure that awarded no permanent disability.

In June 1994, claimant became employed as a bartender at Liberty's insured. (Ex. 8).

On November 29, 1996, claimant sought treatment from Dr. Russo, osteopath, for neck and right shoulder pain that she had experienced for one week. Russo found pain with flexion and extension of the neck and spasm over the right trapezius muscle. X-rays revealed degenerative changes in the neck at C5-6 and C6-7. (Exs. 14, 16).

On January 14, 1997, claimant filed a neck and right shoulder injury claim with Liberty for a November 29, 1996 slip-and-fall incident. (Exs. 15, 16, 18).

On February 13, 1997, Dr. Goodwin evaluated claimant's neck and right shoulder condition. Claimant reported that her current symptoms resulted from her 1994 injury and that she had no problem with the left arm. Goodwin found mild tenderness to palpation in the right upper trapezius, no trigger points, no radicular findings, and no calcific tendonitis. He opined that claimant "may have some very mild myofascial pain in the upper trapezius, but no significant pathology." (Ex. 17).

On June 6, 1997, claimant returned to Dr. Russo. She reported pain in the right shoulder and neck and numbness in the right hand with overhead elevation and certain head movements, which she related to the November 29, 1996 slip-and-fall incident. Russo diagnosed radicular symptoms. An MRI of the cervical spine revealed cervical spondylosis with calcified disc protrusions at C5-6 and 6-7, foraminal narrowing and possible nerve root encroachment. Russo released claimant to light duty "as long as it does not require a lot of overhead excessive extension or flexion of the head as this will aggravate her neck and shoulder." (Exs. 19, 20, 21).

On June 23, 1997, Drs. Melson and Schilperoort examined claimant for Liberty. Claimant reported ongoing symptoms in her right shoulder since the 1994 injury. She complained of pain at the base of the neck and in the right shoulder and hand numbness when reaching on the right. The doctors diagnosed cervical spondylosis with degenerative disc disease (DDD) and found no objective findings of C6-7 radiculopathy. They also diagnosed a chronic shoulder sprain with trapezius and pectoralis involvement secondary to deconditioning and body habitus. They opined that claimant's complaints after the 1996 injury were a recurrence of the 1994 injury, that there may have been a flare-up during the immediate first few weeks after the 1996 injury, but that claimant's worsening symptoms were directly related to progression of degenerative arthritis. (Ex. 22). Dr. Russo concurred. (Ex. 24).

On July 8, 1997, as amended on September 15, 1997, Liberty denied compensability and responsibility for claimant's degenerative neck conditions and chronic right shoulder sprain conditions. (Exs. 25, 32).

On July 17, 1997, Dr. Freeman, neurosurgeon, evaluated claimant's condition. Claimant reported a history of similar neck and right shoulder symptoms without radicular involvement related to the 1994 injury and that she had been free of symptoms just prior to the onset of the November 1996 injury. She also reported that after the November 1996 injury, she had back and neck discomfort that spread into the right shoulder, right and then left hands. Freeman diagnosed a C6 radiculopathy on the right, and recommended a myelogram, CT scan and electrodiagnostic studies to determine whether claimant's symptoms were due to a disk or to a bony growth. (Ex. 26). Electromyographic studies were normal. (Exs. 28, 33).

On July 23, 1997, claimant returned to Dr. Russo complaining of the return of pain in the right shoulder and neck, which she stated was a re-aggravation of the 1994 injury. (Ex. 27).

On August 12, 1997, Dr. Russo filed an aggravation claim with Grocers in regard to the 1994 injury. Grocers denied compensability and responsibility. (Exs. 36, 41).

On September 19, 1997, claimant was examined for Grocers by Drs. Bernstein and Smith. Claimant reported that she had been well between the 1994 and 1996 injuries. Claimant complained of pain in her neck and left shoulder and headaches, which she had never had before, and numbness and tingling in both arms. The doctors diagnosed cervical, occipital and shoulder strain with abnormalities in the neck. (Ex. 33).

On October 2, 1997, Dr. Young evaluated claimant's medical records and imaging studies. (Ex. 35).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld Liberty's denial of claimant's current neck, bilateral shoulder and upper extremity conditions, finding that claimant failed to prove that the alleged November 29, 1996 injury was the major contributing cause of those conditions. On review, claimant contends that her left shoulder and bilateral arm conditions are compensable and that Liberty is responsible. The ALJ also determined that claimant's current right shoulder condition was the same condition as that accepted by Grocers and that Grocers remained responsible for the right shoulder. Grocers contends on review that claimant's current right shoulder condition is not the same condition that it accepted in 1994 and that, therefore, it is not responsible for that condition. We conclude that claimant's current conditions are not compensable as to either insurer for the following reasons.

Left Shoulder and Bilateral Upper Extremity Conditions

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

Claimant contends that she experienced a new injury at Liberty's insured that is the major contributing cause of her need for treatment for her left shoulder and bilateral upper extremity conditions. We disagree.

Claimant began working for Liberty's insured in 1994. On November 29, 1996, she sought treatment from Dr. Russo for neck and *right* shoulder pain that she had been experiencing for about a week. (Ex. 16). Claimant related her condition to the 1994 injury; she made no mention of a fall. (*Id.*; Ex. 45-39). Although claimant filled out a form "827" on January 14, 1997, in which she reported a slip-and-fall incident at work on November 29, 1996, Dr. Russo did not examine claimant at this time and did not know about the slip-and-fall incident until he next saw her on June 6, 1997. (Ex. 15; 45-26, -35, 39, -42, -45).

On February 13, 1997, Dr. Goodwin evaluated claimant's neck and *right* shoulder complaints, which she related to the 1994 injury; claimant did not mention any on-the-job incident. In addition, claimant reported that she had no left upper extremity problems. (Ex. 17). Claimant's documented

complaints continued to involve the *right* shoulder, neck and *right* hand until she was examined by Dr. Freeman on July 17, 1997, who reported discomfort affecting the left hand in addition to the right. (Exs. 19, 22, 23, 26). The first report of left shoulder involvement did not occur until September 19, 1997, when claimant was examined by Drs. Bernstein and Smith. (Ex. 33).

Drs. Bernstein and Smith found tenderness in the AC joint and a positive impingement sign on the right, tenderness in the biceps tendon on the left, and pain on rotation of both shoulders. (*Id.*) The doctors opined that the 1996 injury was the major contributing cause of claimant's need for treatment, as claimant was stable and working until the 1996 injury.

For several reasons, we do not find Bernstein and Smith's opinion persuasive. First, they relied on claimant's own evaluation that pain in her right shoulder was due to the 1994 injury and the pain in her left shoulder, neck and arms was due to her 1996 injury, even though they admitted that they had no way of verifying claimant's evaluation. Second, they relied on claimant's history that the left-sided symptoms began at the time of the 1996 injury, which is not supported by the medical record. Finally, they reasoned that the 1996 injury was the major contributing cause of her need for treatment, because claimant's condition was stable and she was working until the injury. Therefore, because we give the most weight to opinions that are both well-reasoned and based on complete information, we give little weight to Bernstein and Smith's opinion. *Somers v. SAIF*, 77 Or App 259 (1986); *see also Dietz v. Ramuda*, 130 Or App 397, 402 (1994) (the relative contribution of each cause, including the precipitating cause, must be evaluated under the particular circumstances).

On January 14, 1998, Dr. Russo opined that the major contributing cause of claimant's current disability and need for treatment was due to a combination of her preexisting degenerative disc disease and the 1996 injury. (Ex. 42). Russo did not specify that the 1996 injury was the major contributing cause of claimant's combined condition, however. Thus, his opinion is insufficient to carry claimant's burden of proof. Moreover, in his subsequent deposition, Russo admitted that because of inconsistencies in claimant's history, he would have doubts regarding the cause of her condition.[1] (Ex. 45-35).

Because we find the only opinion arguably supporting the compensability of claimant's left shoulder and bilateral arm conditions unpersuasive, we conclude that claimant has failed to establish the compensability of those conditions.

Right Shoulder Condition

The ALJ found that, although claimant testified to continuing right shoulder and neck pain after the 1994 injury, she was an unreliable historian in regard to persistent neck discomfort, based on inconsistencies between claimant's testimony and the medical record, but reliable in regard to persistent right shoulder symptoms. The ALJ then concluded that Grocers remained responsible for claimant's current right shoulder condition under ORS 656.308(1), based on his finding that claimant's current right shoulder condition is the same condition accepted by Grocers in 1994. On review, Grocers contends that claimant's current right shoulder condition is not the same condition that it accepted in 1994. We conclude that claimant's current right shoulder condition is not compensable for the following reasons.

Claimant injured her neck and right shoulder in a 1994 lifting incident. She was diagnosed with a cervical and right shoulder strain and a cervical strain with myofascial pain syndrome involving the right cervical paraspinal area and scapular stabilizers. There is no medical evidence that claimant sought medical treatment for her right shoulder between June 28, 1994 and November 29, 1996. On that date she sought treatment from Dr. Russo for neck and right shoulder pain that she had been experiencing for about a week. X-rays revealed degenerative changes at C5-6 and C6-7, which were confirmed by subsequent imaging studies. Then, in January 1997, claimant reported a slip-and-fall incident that took place at work on November 29, 1996. However, when she was examined by Dr. Goodwin in February 1997, claimant again related her condition to the 1994 injury without mentioning the 1996 on-the-job incident. In June 1997, when she again sought treatment from Dr. Russo, she attributed her neck, right shoulder and arm complaints to the 1996 slip-and-fall.

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[1] After our review of Dr. Russo's opinions, it is unclear to us whether he was addressing the cause of claimant's left shoulder and bilateral arm conditions, or her neck and right shoulder condition, or both, in this report. To the extent that he was addressing the left shoulder and bilateral arm conditions, we find his opinion insufficient to establish compensability.

Also in June 1997, claimant was examined by Drs. Melson and Schilperoort. She dated the onset of her current symptoms to the November 29, 1996 slip-and-fall incident. Claimant also reported that her neck problem was new, which was inconsistent with her history of neck pain in 1994. She also reported for the first time to a doctor that her shoulder had intermittently flared up and had required ice packs since the 1994 injury, which was consistent with her testimony but inconsistent with her reports to Dr. Freeman that she had been completely free of symptoms prior to the 1996 incident and to Drs. Bernstein and Smith that she had been well between the 1994 and 1996 injuries.

Based on claimant's history and imaging studies, Drs. Melson and Schilperoort diagnosed cervical spondylosis with degenerative disc disease, and chronic shoulder pain with trapezius and pectoralis involvement secondary to deconditioning and body habitus. They indicated that claimant appeared to have a chronic shoulder strain since 1994 that would prevent repetitive overhead reaching, opining that the November 1996 injury was 20 percent responsible for claimant's condition and the rest due to the 1994 injury. However, in a later portion of the report, the panel indicated that the worsening of claimant's symptoms was directly related to the progression of her preexisting cervical arthritis. (Ex. 22).

Claimant was examined by Dr. Freeman in July 1997. She again related her problems to the November 1996 incident. She reported to Dr. Freeman that she had had no radicular symptoms after the 1994 injury and was completely free of symptoms just prior to the 1996 injury, when she began having right shoulder and radicular problems down the right arm into the hand and progressively into the left hand. Freeman diagnosed C6 radiculopathy on the right, with possible fresh disc protrusions at C6-7 and C5-6, and bony excrescence to the left at the same levels. (Ex. 26).

Claimant told Drs. Bernstein and Smith, whose report was discussed above, that she missed two weeks of work as a result of the 1994 injury and was able to work at Liberty's insured until her injury there caused her to start missing work in June 1997. The panel found that claimant was medically stationary from the 1994 injury; nevertheless they attributed her current condition to a worsening of that condition as a result of the 1996 injury. (Exs. 33, 34).

Dr. Young, who reviewed the medical records and imaging studies, issued a report of his findings in October 1997. (Ex. 35). This report clearly sets forth the nature and scope of the non-compensable degenerative joint and disc disease in claimant's cervical spine. Based on these findings, Dr. Young opined that claimant had significant degenerative disease in her cervical spine which preexisted both the 1994 and 1996 injuries. He opined that claimant's symptoms and physical findings following her 1994 were similar to those following the 1996 injury. Finally, he opined that, although the degenerative condition may have combined with the 1996 injury, the major contributing cause of claimant's symptoms, treatment and disability was her preexisting degenerative condition. (Ex. 35).

Finally, Dr. Russo reported that claimant had a muscular type of neck and shoulder sprain in 1994 that had resolved long before the November 1996 injury, that imaging studies showed that claimant's degenerative disc disease preexisted her 1994 injury, and that her present need for treatment and disability was not due to the 1994 injury. (Ex. 42).

The medical record establishes that claimant has a severe degenerative condition in her neck that preexisted both the 1994 and 1996 work incidents. Because of the multiple possible causes of claimant's current condition or disability and need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Moreover, as discussed above, claimant's history is unreliable[2] and we do not find those medical reports that rely on that history to be persuasive. *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.

For that reason, we are not persuaded by Melson and Schilperoort's opinion, which relies on claimant's history. In addition, in light of claimant's extensive degenerative condition, and their findings of deconditioning and obesity as contributory factors to claimant's current right shoulder condition, they failed to evaluate the relative contributions of those conditions to claimant's condition. *Dietz v. Ramuda*, 130 Or App at 402 .

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[2] Although claimant testified at hearing that she iced her shoulder and neck every night between the 1994 and 1996 injuries, she did not consistently report this to her doctors.

Moreover, the opinion of Drs. Bernstein and Smith is not sufficient to establish the compensability of claimant's current condition, because they were unable to attribute the major contributing cause of claimant's combined right shoulder condition to the 1994 injury.

Finally, we are more persuaded by the opinions of Dr. Young and Dr. Russo in regard to the 1994 injury. Dr. Russo opined that claimant's November 1994 neck and right shoulder strain injury had resolved prior to November 1996, which is congruent with the medical record. Dr. Young, in his well-reasoned report, persuasively establishes that the major contributing cause of claimant's current complaints was due to her degenerative condition, and not the 1994 injury. Consequently, claimant has failed to establish that her current right shoulder condition is compensable or that it is the same condition that Grocers accepted in 1994.

ORDER

The ALJ's order dated June 30, 1998 is reversed in part and affirmed in part. That portion of the order that set aside Grocers Insurance Group, Inc.'s denial of claimant's right shoulder condition is reversed, and the denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

January 26, 1999 Cite as 51 Van Natta 153 (1999)

In the Matter of the Compensation of
ANA GALVEZ-ALEMAN, Claimant
WCB Case No. 98-00440
ORDER ON RECONSIDERATION
Lundeen, et al, Defense Attorneys

On December 7, 1998, we abated our November 6, 1998 order that affirmed an Administrative Law Judge's (ALJ's) order that dismissed claimant's request for hearing. Having received no response from the insurer or further correspondence from claimant, we now proceed with our reconsideration.

In our order, we found that claimant did not file her request for hearing until January 9, 1998, more than 30 days after the August 1, 1997 Order on Reconsideration. Thus, we concluded that claimant did not timely file her request for hearing. *See* ORS 656.319(4).

In asking for reconsideration, claimant merely states that she disagrees with our decision and has recently retained an attorney, and asks for "another opportunity to present my case." Because claimant does not explain, or even contest, our decision that she did not timely file her request for hearing, we find no reason to change our conclusion that the ALJ properly dismissed her request for hearing. In other words, claimant does not explain how her retention of an attorney shows that she timely filed her request for hearing. Thus, we continue to conclude that the request for hearing should be dismissed.

On reconsideration, as supplemented herein, we adhere to and republish our November 6, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHY L. LAMBERT, Claimant
WCB Case No. 98-04884
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded a $4,500 assessed attorney fee. SAIF moves for remand to the ALJ. On review, the issues are remand and attorney fees.

We deny SAIF's motion for remand and affirm the ALJ's order with the following supplementary reasoning.

At hearing, SAIF agreed to withdraw its denial of claimant's injury claim for a cervical strain and migraines, and to accept those conditions. Thus, the parties only litigated SAIF's denial of claimant's injury claim for a low back condition. The ALJ ultimately set aside that denial, and his order also included the following attorney fee award and supporting rationale:

> "For prevailing against the denial [of claimant's low back condition], claimant's attorney is entitled to the award of an assessed fee. Based upon the principles and factors set forth in OAR 438-015-0010, I assess a fee in the sum of $3,250. Claimant's attorney is also entitled to the award of an assessed fee arising from the insurer's rescission pre-hearing of * * * its denial [of claimant's cervical strain and migraine headaches]. I assess a fee of $1,250."

Pursuant to ORS 656.386(1), a claimant's attorney is entitled to a reasonable assessed fee: (1) for services provided at hearing in prevailing over a denial of a claim; and (2) when a claimant's attorney is instrumental in obtaining a rescission of a denial prior to a decision by an ALJ. In awarding an assessed fee under ORS 656.386(1), an ALJ "shall consider" the eight factors recited in OAR 438-015-0010(4).[1] Here, neither party submitted any argument to the ALJ as to how these factors should be weighed in determining a reasonable fee. And claimant's attorney did not submit a statement of services or make any specific attorney fee request regarding the services provided.

On review, SAIF moves to remand this case to the ALJ for further development of the record and findings of fact regarding the ALJ's attorney fee award. SAIF does not make any specific argument regarding the factors recited in OAR 438-015-0010(4) or otherwise argue that the $4,500 fee award is excessive. Instead, SAIF asserts that the record does not provide a sufficient basis for the Board's review of the ALJ's fee award, and SAIF contends that the ALJ's order is insufficient because he did not make findings of fact regarding each of the eight factors in the rule and demonstrate how these findings should be weighed in determining a reasonable attorney fee. SAIF relies on *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).

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). We found that the *McCarthy* 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. We further reasoned that this rationale applied to OAR 438-015-0010(4) because the

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[1] OAR 438-015-0010(4) lists the following factors to be considered in determining a reasonable fee: the time devoted to the case; the complexity of the issue(s) involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured for the represented party; the risk in a particular case that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses.

statute considered by the Court in *McCarthy* included the same requirement that the reviewing body "shall consider" certain enumerated factors. Thus, 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 request, 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. *Accord Russell L. Martin*, 50 Van Natta 313 (1998) (where claimant did not make a specific fee request and neither party submitted a specific argument regarding the rule-based factors, the ALJ provided a sufficient rationale by stating that the factors recited in OAR 438-015-0010(4) were considered in determining the fee).[2]

Here, as in *McCarthy*, *Underwood* and *Martin*, claimant's attorney did not submit a specific attorney fee request at hearing, and neither party submitted any argument to the ALJ as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, the ALJ satisfied OAR 438-015-0010(4) by citing that rule and noting that he had considered the rule-based factors in awarding the $4,500 assessed fee.

To the extent any further rationale is required, we offer the following supplemental analysis based on the factors in OAR 438-015-0010(4).[3] In so doing, we note that remand is not warranted because the record is sufficiently developed to review the ALJ's attorney fee award, and we have the authority to modify or supplement the ALJ's findings and conclusions. ORS 656.295(5) and (6).[4]

We begin our analysis with the time devoted to the case as represented by the record.[5] In addition, we have particularly considered the complexity of the compensability issue, the value of the interest involved and the benefit secured, the skill of counsel, and the risk that claimant's counsel might go uncompensated.

Claimant retained his attorney three months prior to hearing. The documentary record includes 37 exhibits submitted by SAIF. Claimant's attorney submitted an additional five exhibits, including a dispositive medical opinion authored by Dr. Walker at the request of claimant's attorney. The hearing lasted approximately one hour and was limited to opening and closing argument and testimony from claimant. Based on compensability disputes generally litigated before this forum, we find that this case presented factual, medical and legal issues of average complexity, and that the value of the interest and benefit secured is of average significance. Both attorneys are experienced litigators in the field of workers' compensation law, and claimant's attorney has practiced in this field for many years. Considering the conflicting medical opinions and the standard of proof, there was a risk that claimant's attorney might go uncompensated. After considering these factors, we find that the ALJ's $4,500 fee is reasonable and should be affirmed.

Finally, we note that claimant is not entitled to an assessed fee for his attorney's services on review regarding the assessed fee issue. *See Dotson v. Bohemia Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 25, 1998 is affirmed.

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[2] We found the *Martin* case distinguishable from *Schoch* because the claimant in *Martin* did not make a specific fee request, and neither party submitted a specific argument regarding the rule-based factors.

[3] As noted above, SAIF does not raise any argument on review based on a specific rule-based factor or otherwise argue that the ALJ's $4,500 fee award is excessive.

[4] Pursuant to ORS 656.295(5), we may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1983). Pursuant to ORS 656.295(6), the Board may affirm, reverse, modify or supplement the order of the ALJ and make such disposition of the case as it determines to be appropriate.

[5] Claimant's attorney has not submitted a statement of services rendered at hearing.

In the Matter of the Compensation of
DORIS I. McLEAN, Claimant
WCB Case No. 98-04593
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that awarded claimant's attorney an assessed fee of $3,000 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. Claimant cross-requests review, contending that SAIF should be sanctioned for submitting a frivolous request for review. On review, the issues are attorney fees, remand and sanctions.

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

Attorney Fees

The ALJ awarded claimant's attorney an assessed fee of $3,000 pursuant to ORS 656.386(1). SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4).

We considered a similar 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 Supreme Court's entire decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make specific findings for each rule-based factor.

Here, the ALJ awarded an assessed fee of $3,000 pursuant to ORS 656.386(1). The ALJ stated that he had considered the factors in OAR 438-015-0010(4), particularly the average time devoted to the case, the average complexity of the issue, the average value of the interest involved and benefit obtained, and the significant risk that claimant's attorney's services might have gone uncompensated.

SAIF argues that the ALJ did not consider all eight of the factors in OAR 438-015-0010(4) and it contends that the ALJ made conclusory statements that the time, complexity and value of the case was "average," without explaining why those factors were "average" or making findings of fact that would support a conclusion that this was an average case.

Even if we assume that the ALJ's findings in the case are inadaquately explained, 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.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d)

the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The issue at hearing was whether claimant had established an aggravation claim for a current low back condition. The hearing lasted one hour and 45 minutes. Claimant testified on her own behalf. The record contains approximately 115 exhibits, nine of which were submitted by claimant's attorney. There were no depositions.

Based on aggravation disputes generally litigated before this forum, we find the aggravation issue was of average complexity regarding the legal and factual issues involved.[1] Because claimant's current low back condition has been found compensable, she is entitled to additional workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 regarding the compensability issue 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. Because the only issue on review was attorney fees, claimant is not entitled to an attorney fee on review for her counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

Sanctions

Claimant cross-requests review, contending that SAIF should be sanctioned for submitting a frivolous request for review. She argues that the attorney fee issue raised by SAIF has been decided by the Board at least four times, in *Steven D. Sambuceto*, 50 Van Natta 1812 (1998); *Misty Hayward*, 50 Van Natta 782 (1998); *James F. Shaughessy*, 50 Van Natta 734 (1998); and *Russell L. Martin*, 50 Van Natta 313 (1998). Claimant contends that SAIF has not submitted any new or different arguments that it had not previously argued to the Board in other cases. She submits that SAIF's appeal was "initiated without reasonable prospect of prevailing" and, therefore, she is entitled to sanctions under ORS 656.390.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

Based on the Supreme Court's opinions in *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), 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. Although SAIF's argument on review did not ultimately prevail, we cannot say it was "frivolous." Accordingly, we deny claimant's request for sanctions.

ORDER

The ALJ's order dated September 16, 1998 is affirmed. Claimant's request for sanctions is denied.

[1] Claimant's attorneys have submitted a statement of services, representing that 14 hours of time was expended at the Hearings level. The statement of services indicates a figure of $3,900 as the total "amount of fee sought." Nevertheless, because claimant's respondent's brief asks us to "affirm" the ALJ's order without expressly requesting a greater attorney fee, we do not consider claimant as asking us to increase the attorney fee awarded at hearing. In any event, assuming any such request by claimant, based on the reasoning in this order, we affirm the ALJ's attorney fee award.

In the Matter of the Compensation of
RONALD K. VAUGHN, Claimant
WCB Case No. 98-03152
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's neck, low back and right leg injury claim; and (2) awarded an attorney fee of $4,000 for claimant's counsel's services at hearing. On review, the issues are whether claimant's injury arose out of and in the course and scope of his employment, and attorney fees.

We adopt and affirm the ALJ's order, with the following supplementation to address the attorney fee issue.

For claimant's attorney's services in prevailing over SAIF's denial, the ALJ awarded an assessed fee of $4,000 payable by SAIF. The ALJ determined that the fee amount was reasonable after considering the factors set forth in OAR 438-015-0010(4),[1] in particular the risk of claimant's counsel's efforts going uncompensated.

On review, SAIF contends that the ALJ failed to make findings of fact on each factor listed in the rule in order to demonstrate the reasoning that lead from the facts to the conclusions drawn from those facts. Citing *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), SAIF asserts that the ALJ did not state a sufficient rationale to determine whether a fee of $4,000 was reasonable.[2] We find, however, that *Schoch* is distinguishable on its facts and that the ALJ's stated rationale for the fee award was sufficient given the record at hearing. *Russell L. Martin*, 50 Van Natta 313 (1998) .

Here, as in *Martin*, the record does not contain a specific attorney fee request (or statement of services), nor does it appear that the parties submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. The absence of a fee request or argument on the rule-based factors distinguishes this case (as in *Martin*) from *Schoch*. Under these circumstances, the ALJ was not obligated to make specific findings regarding the rule-based factors, in order to have a reviewable order. It was enough for the ALJ to state that she had considered the rule-based factors (with particular emphasis on the factor of risk), in reaching her decision that $4,000 was a reasonable fee. Therefore, under the circumstances of this case, the ALJ's explanation for the fee award was sufficient compliance with the Schoch Court's instruction to provide a rational connection between consideration of the factors and the amount of the fee awarded. *Martin*, 50 Van Natta at 315.

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[1] OAR 438-015-0010(4) provides:

"In 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."

[2] SAIF notes in its brief that it is not contending *at this point* that the $4,000 fee is excessive. Rather, SAIF argues that there is insufficient information from which it can be determined whether the fee is excessive.

However, considering that further appellate review of our decision would be subject to the "range of discretion" criteria discussed in *Schoch*, we provide the following supplementation to the ALJ's decision.

We consider the amount of claimant's counsel's attorney fee by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute concerned compensability of claimant's new injury claim, specifically whether claimant was in the course and scope of his employment when the injury occurred. Twenty-two exhibits were admitted at hearing, with 12 exhibits submitted by claimant's attorney. The hearing lasted two and three-quarters hours and the transcript is 99 pages long. Two witnesses testified, including claimant.

SAIF stipulated to the ALJ that claimant was injured in the course of his employment. Thus, the dispute before the ALJ was whether the injury arose out of claimant's employment. Considering the discrepancies between claimant's and Mr. Smit's testimonies, the "arising out of" issue was of greater legal complexity than the typical "course and scope" disputes that come before the Hearings Division. The value of the interest involved and the benefits secured for claimant were average, in that claimant will now receive medical and other benefits for his injury, including possible permanent disability. Both attorneys are skilled and experienced in the area of workers' compensation law and they presented their arguments in a thorough and well-reasoned manner. Because there was divided evidence and a vigorous defense, we find that there was an above average risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses were asserted.

After applying the factors discussed above, we find that the ALJ's attorney fee award of $4,000 is reasonable for claimant's counsel's services at hearing. In affirming the ALJ's fee, we have particularly relied on the legal complexity of the "arising out of" issue, the time devoted to the issue (as represented by the record), the value of the interest involved, the benefits secured, and the risk that counsel might go uncompensated.

Moreover, based on similar considerations, we find that $1,000 is a reasonable assessed fee for claimant's counsel's efforts in defending the compensability issue on Board review.[3]

ORDER

The ALJ's order dated August 13, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the SAIF Corporation.

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

Board Member Moller dissenting.

I disagree with the majority's conclusion that claimant satisfied his burden of proving that his injuries arose out of his employment when he was injured while attempting to prevent two men from repossessing his girlfriend's van. Because I believe that his risk of injury arose from something personal to claimant, *i.e.*, his girlfriend's failure to timely make payments on her van, I must dissent.

A compensable injury is an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). Two elements must be evaluated 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," which concerns the time, place and circumstances of the injury; and (2) "arising out of employment," which tests the causal connection between the injury and the employment. Neither element is dispositive. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994).

Here, claimant alleges that the repossessing agents injured him when they rammed claimant's van with their towing vehicle and then nearly ran over him while they were backing up to the van. At the time, claimant was trying to resist their attempts. If the motivation for an assault 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 location for the assault, the assault does not "arise out of employment." *Redman Industries, Inc. v. Lang*, 326 Or 32, 35-36 (1997).

In *Lang*, the Court stated:

> "In prior cases interpreting ORS 656.005(7)(a), this court has held that the inquiry into whether an injury 'arises out of employment' tests the causal connection between the injury and the employment. A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. A causal connection must be linked to a risk connected with the nature of the work or a risk to which the work environment exposed claimant."

The Court also quoted with approval the following passage from *Larson*:

> "When the animosity or dispute that culminates in an assault is imported into the employment from claimant's domestic or private life, and is not exacerbated by the employment, the assault does not arise out of the employment under any test. 1 *Larson's Workers' Compensation Law*, section 11.21(a) at 3-314."

Redman Industries, 326 Or at 40.

Although the ALJ found significant the fact that claimant was required to provide a vehicle for his employment and that the vehicle was, according to the terms of claimant's employment, under the possession and control of the employer during work hours, I do not find these facts to be determinative of the arising out of employment element of the unitary test. Rather, for purposes of determining whether claimant's injury arose out of his employment, the focus is more appropriately placed on the direct circumstances of the injury, *i.e.* the risk that has resulted in the injury.

In this regard, I would distinguish the facts of this case from those in *Herbert J. Logsdon*, 48 Van Natta 56 (1996). In *Logsdon*, as here, the claimant was employed as a delivery driver. Further, both here and in *Logsdon*, the claimants' injuries resulted from altercations involving third parties. However, in *Logsdon*, the altercation resulted from "the various hazards associated with driving an automobile, including being 'cut-off' in traffic and engaging in personal exchanges (non-verbal, verbal and physical)." Because the claimant's employment placed claimant in the position of having to deal with the "hazards of driving", the Board in *Logsdon* determined that the claimant's injury arose out of his employment. Here, by contrast, claimant's injury did not result from the normal hazards of driving to which his employment subjected him. Had his injury resulted from such hazards, then I would agree with the majority that his claim is compensable. Instead, claimant's injury here resulted from a dispute that was imported into claimant's employment from his domestic or private life.

Accordingly, I would find that claimant's injury does not arise out of his employment and, therefore, is not compensable.

In the Matter of the Compensation of
CLARENCE A. MOORE, Claimant
WCB Case Nos. 98-00560 & 97-06763
ORDER OF ABATEMENT
Scott McNutt, Sr., Claimant Attorney
James B. Northrop (Saif), Defense Attorney
William J. Blitz, Defense Attorney

On January 13, 1999, we affirmed an Administrative Law Judge's (ALJ's) order that found Barrett Business Services responsible for claimant's right knee medial meniscus tear condition. Submitting information indicating that its counsel only recently received a copy of claimant's respondent's brief, Barrett seeks either the rejection of claimant's brief or an extension of time within which to reply to claimant's respondent's brief.

In light of such circumstances, we grant Barrett an opportunity to file a supplemental reply brief which addresses claimant's respondent's brief. (This reply brief would supplement Barrett's previous reply brief that pertained to the SAIF Corporation's respondent's brief.)

Accordingly, we withdraw our January 13, 1999 order. Barrett's supplemental reply brief must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD G. YOUNG, Claimant
WCB Case No. 98-03217
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
James P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that awarded an assessed attorney fee of $3,500 pursuant to ORS 656.386(1). On review, the issue is attorney fees.

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

The ALJ set aside SAIF's denial of claimant's injury/occupational disease claim for an L5-S1 disc herniation and awarded an assessed attorney fee of $3,500 pursuant to ORS 656.386(1). Citing *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), SAIF asserts that the ALJ did not state a sufficient rationale to support the $3,500 fee award. SAIF moves to remand the case to the ALJ to make reviewable findings supporting the award of attorney fees in light of the factors in OAR 438-015-0010(4).[1]

The record contains no specific attorney fee request, such as a statement of services, nor does it appear that the parties submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, the ALJ was not obligated to make specific findings regarding the rule-based factors in order to have a reviewable order. *Russell L. Martin*, 50 Van Natta 313 (1998) (the absence of a fee request or argument based on the rule-based factors distinguished the case from *Schoch*, 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). *See also McCarthy v. Oregon Freeze Dry Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998) (Court of Appeals would satisfy its obligation to make findings under attorney fee statute by including a brief description or citation to the factor or factors relied on in denying an award of attorney fees; standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal).

Accordingly, it was sufficient for the ALJ to state that she had considered the rule-based factors, with particular emphasis on three of the factors (complexity, value of the interest, benefit secured). *See Daryl L. Underwood*, 50 Van Natta 2330 (1998). Therefore, we find the ALJ's order adequate for review.

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[1] SAIF does not contend that the ALJ's attorney fee award is excessive. OAR 438-015-0010(4) provides that the following shall be considered in determining a reasonable attorney fee: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

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. ORS 656.295(5). Consequently, we deny SAIF's motion for remand. *Daryl L. Underwood*, 50 Van Natta at 2332.

Finally, in addition to the ALJ's discussion, we provide the following reasoning. With regard to the time factor, we further note that the hearing lasted one hour and two witnesses testified. The record consisted of 26 exhibits, including one medical report obtained by claimant's attorney.

Compared to compensability disputes generally presented to this forum for resolution, we find the compensability issue to be of average complexity. The value of the interest involved and the benefit secured for claimant was significant because claimant underwent surgery. (Ex. 17). Because the medical reports concerning the compensability of the herniated disc were divided, there was a risk claimant's attorney might go uncompensated. Finally, both attorneys were experienced and skillful.

Based on these factors, especially the value of the interest involved, the benefit secured, and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $3,500 is a reasonable attorney fee for claimant's counsel's services at hearing regarding the compensability issue. Thus, we affirm.[2]

ORDER

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

[2] Claimant's attorney is not entitled to an assessed fee on review for defending the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

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

Douglas County Forest Products/Liberty Northwest (DCFP/Liberty Northwest) requests reconsideration of our December 28, 1998 Second Order on Remand, asking that we reconsider the responsibility ruling in the first Order on Remand. In our first Order on Remand, we set aside DCFP/Liberty Northwest's denial of claimant's occupational disease claim for bilateral hearing loss. DCFP/Liberty Northwest contends that Murphy Plywood/Liberty Northwest is responsible for claimant's condition.

In order to further consider DCFP/Liberty Northwest's request, we withdraw our prior order. Claimant and the other carriers are granted an opportunity to respond. To be considered, each 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
CORINNE L. BIRRER, Claimant
WCB Case Nos. 98-01138, 98-01097 & 98-01095
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its denials of claimant's current left wrist condition as procedurally improper; and (2) set aside the March 5, 1998 Order on Reconsideration and remanded the accepted left wrist component to the Department of Consumer and Business Services for a full and complete medical arbiter examination. On review, the issues are the propriety of the employer's denials of claimant's current left wrist condition, compensability of that condition and extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant, age 45 at the time of hearing, has been working as a medical claims processor for the employer since May 1995. (Tr. 6-7). She has performed primarily data entry work since age 17. (Tr. 7). Claimant's work for the employer mainly involved keyboarding. (Tr. 6).

In January 1996, claimant filed a claim for a left wrist condition. (Ex. 1). The employer accepted a nondisabling left wrist strain. (Ex. 2). Claimant has been treated by Dr. Rabie since November 1995. (Tr. 9). On August 7, 1996, Dr. Rabie reported that claimant's left wrist tendinitis had resolved and she was medically stationary without evidence of permanent impairment. (Ex. 3).

On August 8, 1996, claimant signed an "801" form for a right wrist condition, stating that her right wrist began hurting on July 17, 1996. (Ex. 4). Dr. Rabie examined claimant on August 8, 1996 and diagnosed right flexor and extensor wrist tendinitis. (Ex. 5). The employer initially accepted nondisabling right wrist tendinitis, which was later changed to disabling. (Exs. 6, 8).

On April 29, 1997, Dr. Wright performed surgery on claimant's left wrist. (Ex. 10). His diagnosis was left intersection syndrome of the wrist. (*Id.*) Dr. Rabie felt that claimant's left wrist surgery was related to her open claim. (Ex. 12). Claimant was off work from January 2, 1997 until October 29, 1997. (Tr. 12).

On September 4, 1997, claimant was examined by Dr. Nolan on behalf of the employer. (Ex. 13). He found no diagnosable condition in either of claimant's upper extremities. (Ex. 13-3). Dr. Nolan reported that claimant had a multitude of subjective complaints that outweighed any objective abnormalities. (*Id.*) He found no measurable impairment and he felt that claimant was medically stationary and could return to her regular work. (Ex. 13-4). Dr. Rabie agreed that claimant's right wrist was medically stationary without permanent impairment. (Ex. 15-2). A Notice of Closure for claimant's right wrist condition issued on October 29, 1997 that did not award any permanent disability. (Ex. 17).

In September 1997, Dr. Rabie signed a Notice of Claim for Aggravation of Occupational Injury or Disease. (Ex. 14-1). His August 13, 1997 chart note indicated that claimant had right elbow problems. (Ex. 14-2).

On December 18, 1997, Dr. Rabie responded to the employer's letter by stating that claimant's left wrist condition was initially related, in major part, to her work activities. (Ex. 22-3). He said that the left wrist condition had not resolved after treatment, the passage of time and removal from keyboard activities. (*Id.*) Dr. Rabie felt that claimant's current left wrist conditions were no longer related to work. (*Id.*)

On January 28, 1998, the employer modified the acceptance to include disabling right wrist tendonitis and left wrist tendonitis/intersection syndrome. (Ex. 23). On the same date, the employer issued a denial of claimant's claim for benefits on the basis that her compensable injury was no longer the major contributing cause of the disability and need for treatment of her left wrist condition. (Ex. 24). The employer also issued a denial of claimant's right elbow condition. (Ex. 25-2).

On February 2, 1998, the employer issued an updated notice of acceptance at closure, indicating it had accepted disabling right wrist tendonitis and left wrist tendonitis/intersection syndrome. (Ex. 27). A Notice of Closure issued the same day that did not award any permanent disability. (Ex. 28). On the same date, the employer issued a denial of the left wrist condition on the basis that claimant's compensable injury was no longer the major contributing cause of the disability and need for treatment of her left wrist condition. (Ex. 29).

On February 2, 1998, Dr. Nathan performed a medical arbiter examination. (Ex. 30). He noted that the accepted condition was right wrist tendinitis. (Ex. 30-1). His examination was limited to both of claimant's upper extremities. (Ex. 30-2). He found no objective evidence of residuals from the right wrist tendinitis. (Ex. 30-4). He also noted that there were no objective findings with regard to the left intersection syndrome "but this was not included in assessment for impairment." (*Id.*)

On February 20, 1998, the Department wrote to Dr. Nathan, informing him that claimant had an additional accepted condition, *i.e.*, left wrist tendonitis/intersection syndrome. (Ex. 31). The Department asked Dr. Nathan if the reported decreased ranges of motion for the left wrist were due to the accepted condition and whether claimant was "significantly limited in the ability to repetitively use the left hand, wrist/ forearm[.]" (*Id.*)

Dr. Nathan responded that his observations of claimant's left wrist were general in nature, since the left wrist condition had not been accepted at the time of his examination. (Ex. 33-1). He reported that his left wrist exam did not reveal the presence of any objective findings that he felt would be direct residuals from the intersection syndrome. (*Id.*) He noted that he had not specifically examined claimant to determine the source of the reduced range of motion in her left wrist. (*Id.*) Dr. Nathan did not believe there was any significant limitation in claimant's ability to the left hand and wrist/forearm due to a diagnosed chronic and permanent condition arising out of the accepted condition. (*Id.*)

On February 23, 1998, an Order on Reconsideration issued, affirming the October 29, 1997 Notice of Closure, which pertained to the right wrist tendonitis claim. (Ex. 32). On March 5, 1998, an Order on Reconsideration issued, affirming the February 2, 1998 Notice of Closure, which pertained to the right wrist tendonitis and the left wrist tendonitis/intersection syndrome. (Ex. 34).

CONCLUSIONS OF LAW AND OPINION

Left Wrist Condition

The ALJ found that the employer's January 28, 1998 denial of claimant's left wrist condition was identical to the February 2, 1998 denial, except for two sentences added to the February 2, 1998 denial. The ALJ determined that the January 28, 1998 denial merged with the February 2, 1998 denial and no longer separately existed. The ALJ reasoned that, because the February 2, 1998 denial of claimant's left wrist condition was issued on the same day that the left wrist claim was closed, that denial could not be considered a preclosure denial. The ALJ concluded that the employer's denial pursuant to ORS 656.005(7)(a)(B) was procedurally improper because there had not been an acceptance of a preexisting condition or a combined condition.

After the ALJ's order, we decided *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (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)[1] 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 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.

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[1] ORS 656.262(7)(b) provides that "[o]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

Here, the employer issued denials of claimant's claim for benefits on January 28, 1998 and February 2, 1998, asserting that the compensable injury was no longer the major contributing cause of her disability and need for treatment of the current left wrist condition. (Exs. 24, 29). The employer relies on Dr. Rabie's opinion that claimant's current left wrist condition was no longer related to her work activities to support its current condition denials. The employer acknowledges, however, that the record is not "crystal-clear" that claimant's accepted condition combined with a preexisting condition.

For the following reasons, we agree with claimant that there is no evidence that her accepted condition combined with a preexisting condition to cause or prolong her disability or need for treatment. We find no persuasive evidence that claimant had a "preexisting condition."[2] The employer relies on part of Dr. Rabie's December 18, 1997 report:

> "This leads me to believe that whatever is causing her current ongoing [left] wrist symptoms is no longer related to work but another intrinsic factor, possibly psychological, but I cannot say for sure since that (secondary gain/psychological distress) is out of my field of expertise." (Ex. 22-3).

Dr. Rabie is board-certified in emergency medicine and occupational medicine. (Ex. 35-5). In his December 18, 1997 report, he expressly commented that he was not an expert in psychological issues and he referred to the possibility that claimant had a psychological condition. (Ex. 22-3). Dr. Rabie's opinion is not persuasive because it establishes only a possibility that claimant had a psychological condition. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981). Moreover, Dr. Rabie did not indicate whether or not the alleged psychological condition preexisted claimant's work activities with the employer. Consequently, we are not persuaded that claimant has a preexisting condition. In any event, even if we assume that claimant had a preexisting condition, Dr. Rabie's opinion is not sufficient to establish that claimant's work activities combined with the "preexisting condition" to cause or prolong disability or a need for treatment pursuant to ORS 656.005(7)(a)(B). We are not persuaded by the employer's "combined condition" argument.

Because we are not persuaded that claimant has a "combined condition," ORS 656.262(7)(b) does not provide a basis for upholding the employer's denials. Nevertheless, there is no prohibition against issuing a preclosure partial denial of a condition separate from the accepted condition. *Johnson v. Spectra Physics*, 303 Or 49, 57-58 (1987); *Tattoo v. Barrett Business Service*, 118 Or App 348, 353-54 (1993) (carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status). In *Zora A. Ransom*, 46 Van Natta 1287 (1994), the employer issued a denial of the claimant's current low back strain condition two days before claim closure. Because the medical evidence from the claimant's attending physician "unequivocally" indicated that the claimant's current low back strain condition was not related to the accepted low back strain, we upheld the employer's preclosure denial.

Here, the medical evidence establishes that claimant's current left wrist condition is no longer related to the accepted left wrist tendonitis/intersection syndrome. Dr. Rabie has been claimant's treating physician since November 1995. (Tr. 9). Although he felt that claimant's left wrist condition was initially related, in major part, to her work activities (Exs. 22-3, 35-8), he subsequently concluded that her current left wrist symptoms were no longer related to her work activities. Dr. Rabie agreed that he began to doubt that claimant's work activities were the major contributing cause of her problems when her condition did not improve with reduced activities. (Ex. 35-10). He explained that claimant had been off work for a very protracted period of time and had no improvement during her time off. (Ex. 35-12). Dr. Rabie was not even sure that claimant's work activities were a material factor in her current left wrist condition. (*Id.*) Furthermore, he was not certain that claimant still had an underlying tendonitis condition. (Ex. 35-14).

The only other medical opinion on causation was from Dr. Nolan, who concluded that claimant had no diagnosable condition in either of her upper extremities. (Ex. 13-3). Dr. Nolan reported that claimant had a multitude of subjective complaints that outweighed any objective abnormalities. (*Id.*) He did not believe claimant's complaints were related to her typing activities at work. (Ex. 13-4).

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[2] 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 injury or occupational disease[.]" ORS 656.005(24).

Based on the reports from Drs. Rabie and Nolan, we conclude that claimant's current left wrist condition is no longer related, in major or material part, to her accepted left wrist tendonitis/intersection syndrome. Consequently, we uphold the employer's preclosure denials. *See Joey D. Smalling*, 50 Van Natta 1433 (1998) (because medical evidence at claim closure unequivocally indicated that the claimant's right ankle instability condition was not related to the previously accepted right ankle sprain, the carrier's denial was a valid "pre-closure" denial); *Zora A. Ransom*, 46 Van Natta at 1287.

March 5, 1998 Order on Reconsideration

The ALJ found that Dr. Nathan's medical arbiter examination was insufficient regarding claimant's left wrist condition. The ALJ set aside the March 5, 1998 Order on Reconsideration and remanded the accepted left wrist component of the claim to the Department for completion of a full and complete medical arbiter examination.

The employer argues that the ALJ erred in remanding the matter to the Department. The employer contends that the arbiter examination was sufficient and the March 5, 1998 Order on Reconsideration should be affirmed.

Under OAR 436-035-0007(1) (WCD Admin. Order 96-072), a worker is entitled to a disability rating for findings of impairment that are permanent and were caused by the compensable injury or disease. OAR 436-035-0007(13) provides that on reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion established a different level of impairment. We rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Claimant's accepted condition is left wrist tendonitis/intersection syndrome. (Exs. 23, 27). At the time Dr. Nathan performed the arbiter examination on February 2, 1998, he was under the impression that the only accepted condition was right wrist tendinitis. (Ex. 30-1). Although his examination was of both claimant's upper extremities (Ex. 30-2), he was not informed about the additional accepted condition of left wrist tendonitis/intersection syndrome until February 20, 1998. (Ex. 31). On February 24, 1998, Dr. Nathan reported that his examination of claimant's left wrist "did not reveal the presence of any objective findings which I felt would be direct residuals from the previously-diagnosed and operated intersection syndrome." (Ex. 33-1). Nevertheless, Dr. Nathan had not specifically examined claimant to determine the source of the reduced range of motion observed in the left wrist. (*Id.*)

Despite the fact that Dr. Nathan had not determined the source of the reduced range of motion in claimant's left wrist, we do not agree with the ALJ that the matter should be remanded the matter to the Department for another medical arbiter examination.[3] Dr. Nathan found no objective findings of any residuals from claimant's left wrist intersection syndrome. (Ex. 33-1). Although Dr. Nathan did not specifically comment about any residuals from claimant's left wrist tendonitis, Dr. Rabie, claimant's treating physician, testified that he was not certain claimant still had an underlying tendonitis condition. (Ex. 35-14). Furthermore, Dr. Rabie was not sure that claimant's work activities were even a material factor in her current condition. (Ex. 35-12). As we discussed earlier, we have upheld the employer's denials of claimant's current left wrist condition in light of our conclusion that claimant's current left wrist condition is no longer related, in major or material part, to her accepted left wrist tendonitis/intersection syndrome. Based on the reports from Drs. Rabie and Nolan, we conclude that the preponderance of medical opinion establishes that claimant has no impairment from her accepted left wrist condition. Consequently, we affirm the March 5, 1998 Order on Reconsideration.

ORDER

The ALJ's order dated September 4, 1998 is reversed. The self-insured employer's denials are reinstated and upheld. The ALJ's attorney fee award is reversed. The March 5, 1998 Order on Reconsideration is reinstated and affirmed.

[3] In any event, we note that the ALJ did not have the authority to remand this matter to the Department for the appointment of a medical arbiter. *Dennis R. Loucks*, 50 Van Natta 1779 (1998).

In the Matter of the Compensation of
BILL T. BRANSTETTER, Claimant
WCB Case No. 97-05094
ORDER ON REVIEW
Bottini, Bottini & Oswald, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that dismissed his request for hearing. On review, the issue is the propriety of the dismissal order. We affirm.

FINDINGS OF FACT

Claimant has an accepted and closed claim for a thoracic sprain. A hearing was set for September 18, 1997. Because claimant's attorney withdrew representation shortly before the hearing, the hearing was postponed and reset for February 25, 1998.

Before the rescheduled hearing, claimant again asked for postponement and a change of venue because claimant's "wife was ill and required his constant attention." That motion was granted and a hearing was reset in Pendleton for July 7, 1997. The Order of Postponement stated that "claimant was advised it was unlikely this matter would be postponed again on the same basis." Claimant did not appear in person or through an attorney at the July 7, 1997 hearing.

The ALJ then issued an Order of Dismissal on the basis that the request for hearing had been abandoned. After claimant moved for abatement, the ALJ issued an Order to Show Cause and provide extraordinary circumstances for his failure to attend the hearing. Claimant responded with the explanation that he was in Idaho with his wife, who suffers from dementia; his wife's medication ran out; and he had difficulty in getting a physician's authorization to refill the prescription. As claimant stated, "when we received authorization and got the medicine it was to [sic] late make the Hearing."

The ALJ then issued the Order of Dismissal, finding that claimant had not complied with the terms of the show cause order or demonstrated that he was entitled to a third postponement of his request for hearing.

CONCLUSIONS OF LAW AND OPINION

On review, claimant continues to assert that he was unable to attend the hearing because he was attempting to obtain medication for his wife in Idaho and that such medication is "essential." Although claimant also indicates that he attached with his brief a statement from his wife's physician attesting to the necessity of the medication, we find no such statement. The self-insured employer responds that claimant's explanation constitutes a "nonemergency situation" because claimant could have foreseen that he lacked sufficient medication and taken measures to obtain it before the hearing.

Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-006-0071(2). An ALJ shall dismiss a request for hearing if claimant or his attorney fail to attend a scheduled hearing, unless "extraordinary circumstances" justify postponement or continuance of the hearing. OAR 438-006-0071(2). OAR 438-006-0081 provides that a "scheduled hearing shall not be postponed except by order of an Administrative Law Judge upon finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement."

Here, we agree with the ALJ's finding that claimant did not show "extraordinary circumstances beyond [his] control[.]" In particular, as noted by the ALJ, claimant's request for hearing had already been postponed twice. Furthermore, although claimant apparently was in the process of obtaining necessary medication for his wife, claimant did not show that such situation was "beyond his control." That is, as argued by the self-insured employer, it appears that claimant could have made such arrangements before the hearing; in particular, well before the hearing, claimant could have examined the "bag" of medications he was given, realized it was insufficient, and made the necessary arrangements with a physician and pharmacy to obtain refills.

Consequently, because neither claimant nor an attorney appeared on his behalf at the scheduled time of the hearing, and because we have concluded that no "extraordinary circumstances" justified postponement of the hearing, we affirm the ALJ's dismissal of claimant's hearing request. OAR 438-006-0071(2).

ORDER

The ALJ's order dated September 29, 1998 is affirmed.

In the Matter of the Compensation of
LANNY K. SIGFRIDSON, Claimant
WCB Case No. 98-04142
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his injury claim for an L4-5 disc herniation. 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 L4-5 disc herniation, finding that claimant had failed to prove that his compensable August 27, 1997 injury was the major contributing cause of that condition. In reaching his decision, the ALJ found the medical opinion of the only physician who supported compensability, Dr. Gallo, unpersuasive.

On review, claimant argues that Dr. Gallo's opinion is more persuasive than those of examining physicians, Drs. Schilperoort and Farris, who concluded that a preexisting degenerative condition was the major cause of claimant's herniated disc. Claimant asserts that Dr. Gallo has superior expertise because she is a neurosurgeon, whereas Drs. Schilperoort and Farris are not. Even assuming that claimant is correct that Dr. Gallo has the preferred credentials, we, nevertheless, agree with the ALJ's reasons for discounting Dr. Gallo's opinion. Thus, we concur with the ALJ's decision to uphold SAIF's denial.

ORDER

The ALJ's order dated September 25, 1998 is affirmed.

In the Matter of the Compensation of
JERROLD D. GLOVER, Claimant
WCB Case No. 98-04610
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its partial denial of claimant's injury claim for a left wrist scaphoid nonunion condition. On review, the issues are issue preclusion and compensability. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

A prior ALJ's April 23, 1988 Opinion and Order involving the same parties determined only that claimant was not entitled to temporary disability compensation under this claim as of September 24, 1997.

Claimant's preexisting left wrist scaphoid nonunion condition and his injury-related trapezoid cyst fracture combined to cause his need for treatment for his left wrist until August 18, 1997. Claimant's injury-related trapezoid cyst fracture was the major contributing cause of his need for treatment during this time. (*See* Ex. 8).

As of August 18, 1997, the March 12, 1997 work injury was no longer the major contributing cause of claimant's left wrist condition or his disability or need for treatment for that condition. (*See* Exs. 15, 16, 17, *see also* Ex. 25-3).

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Discussion of Findings" and "Conclusions of Law" except for the last four paragraphs, with the following modification and supplementation.[1]

The ALJ found that Dr. Jewell's July 15, 1998 opinion supports a finding that claimant's March 12, 1997 work injury combined with his preexisting scaphoid nonunion condition to "contribute to claimant's disability or need for treatment." (Opinion and Order, p.3) We agree that the medical evidence, including Dr. Jewell's 1998 opinion, supports a finding that the injury and the preexisting condition *initially* combined to cause claimant's need for treatment (including his need for the May 29, 1997 left wrist surgery). But Dr. Lynch, treating surgeon, explained that the work injury *no longer* contributed to claimant's left wrist condition as of August 18, 1997. (Exs. 15, 16, 17). Considering Dr. Lynch's advantage as claimant's treating surgeon and her well-reasoned opinion, we find no persuasive reason to discount her opinion in this regard. Accordingly, based on Dr. Lynch's opinion,[2] we conclude

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[1] Regarding issue preclusion, we note that the prior ALJ found that "the need for treatment of the scaphoid nonunion was probably not due to the work injury." (Ex. 25-1). But the substantive issue at the prior hearing was claimant's entitlement to temporary disability for the period beginning September 24, 1997. (*See* id.). Thus, the prior litigation necessarily determined only the cause of claimant's disability as of September 24, 1997. The ALJ did not determine the cause of claimant's need for treatment for his scaphoid nonunion at any time period *before* September 24, 1997. (*See* Ex. 25-3). Accordingly, to the extent that the current issue involves the compensability of claimant's left wrist condition (including his need for treatment therefore) before September 24, 1997, the issue is not precluded by the April 23, 1998 Opinion and Order. *See e.g., Patrick Duffy*, 41 Van Natta 1478, 1482 (1989) (Compensability issue not precluded because not essential to prior litigation); *see also Chavez v. Boise Cascade Corp.*, 307 Or 632, 637 (1989) ("[T]o make a claimant appeal an otherwise satisfactory award only to eliminate the preclusive effect of unrequested and nonessential findings would not further the procedural objectives of preclusion. . . .").

[2] We note that Dr. Jewell examined claimant on May 21, 1998 and specifically referred to the cause of claimant's *current* need for treatment in his July 1998 report. (Ex. 30-3). However, because Dr. Lynch's opinion establishes that claimant's left wrist condition was not work related as of August 18, 1997 (and Dr. Jewell did not explain how it became work related again thereafter), we do not find Dr. Jewell's conclusions persuasive insofar as they address claimant's 1998 condition.

that claimant's combined left wrist condition was compensable before, but not on or after, August 18, 1998. *See Danny B. Conner, on remand* 48 Van Natta 1227, 1228 (1996) (Combined condition compensable only until injury was no longer the major contributing cause of ongoing problems); *Lavern E. Jones*, 48 Van Natta 311 (1996) (same).

Because we have partially upheld the insurer's denial, we modify the ALJ's attorney fee award as follows. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing under ORS 656.386(1) for the "pre-August 18, 1998" compensability issue is $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the "pre-August 18, 1998" compensability issue is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the "post-August 18, 1998" compensability issue.

ORDER

The ALJ's order dated October 9, 1998 is reversed in part, modifed in part, and affirmed in part. The insurer's denial is reinstated and upheld insofar as it denies claimant's left wrist condition after August 18, 1998. That portion of the denial which denied claimant's left wrist condition before August 18, 1998 is set aside and the claim is remanded to the insurer for processing according to law. In lieu of the ALJ's attorney fee award, claimant is awarded an $1,800 attorney fee for services at hearing, payable by the insurer. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $1,200 attorney fee, payable by the insurer.

January 28, 1999 Cite as 51 Van Natta 170 (1999)

In the Matter of the Compensation of
BARBARA D. HODGIN, Claimant
WCB Case No. 98-04578
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its denial of claimant's injury claim for right knee and low back conditions; and (2) awarded a 25 percent penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

Compensability

Claimant, a dietary aide, alleged that she injured her right knee and low back when she slipped and fell at work on September 1, 1997. The ALJ set aside the insurer's denial of claimant's injury claim, finding that claimant had established the September 1997 work incident was a material contributing cause of her low back and right knee conditions. In so doing, the ALJ acknowledged that there were inconsistencies in the record, but that they were not sufficient to defeat the claim.

We agree with the ALJ's reasoning and conclusions on the compensability issue. The insurer, however, contends on review that the ALJ "glossed over" or did not address all inconsistencies. For instance, the insurer cites a March 16, 1998 claim history questionnaire in which claimant filled out the section required to be completed if symptoms appeared gradually, rather than as a result of a specific accident. (Ex. 5).

Arguably, claimant's completion of the "Gradual Onset" portion of the form is inconsistent with the nature of her claim. Claimant, nevertheless, recounted the slip and fall on the questionnnaire (albeit in the wrong section) and attributed her right knee and low back symptoms to that incident. After considering the insurer's contentions, we are not persuaded that the alleged inconsistencies are sufficient to seriously detract from the ALJ's finding that the September 1, 1997 incident was a material factor in claimant's right knee and low back conditions. Accordingly, we affirm.

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

Penalties

The ALJ assessed a 25 percent penalty pursuant to ORS 656.262(11)(a) because the insurer failed to issue its denial of claimant's right knee condition within 90 days of its receipt (March 19, 1998) of the claim history questionnaire, which, according to the ALJ, clearly indicated that claimant was claiming that she injured her right knee as a result of the work incident. *See* ORS 656.262(6)(a). On review, the insurer contends that the questionnaire was not a claim for the right knee condition. We disagree.

A carrier has 90 days in which to accept or deny a claim after notice or knowledge of the claim. ORS 656.262(6)(a). 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). 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).

Although claimant has alleged that her right knee was injured as a result of a specific traumatic incident on September 1, 1997, as we previously noted, she filled out the portion of the claim history questionnaire that indicated that her symptoms were of "Gradual Onset." (Ex. 5-2). Claimant, however, stated that her symptoms were in several locations, including the right knee. When asked what work activities caused her symptoms, she recounted her work-related slip and fall. Although the insurer contends that medical evidence linking the right knee to work must have accompanied the form before it could be considered a "claim," ORS 656.005(6) merely requires a written request for compensation from the worker. Medical evidence is not required to accompany a "claim" under ORS 656.005(6). *Compare* ORS 656.273(3) (claim for aggravation must be accompanied by report from attending physician).

Therefore, we agree with the ALJ that the questionnaire was a "claim" for the right knee condition. Because the insurer received the form on March 19, 1998 and did not issue its denial of claimant's right knee claim until August 18, 1998, more than 90 days after notice of the claim, its denial was untimely. ORS 656.262(6)(a). Furthermore, we agree with the ALJ that the insurer's failure to timely process the right knee claim was unreasonable. Therefore, we agree with the ALJ's decision to assess a penalty.[1]

ORDER

The ALJ's order dated September 25, 1998 is affirmed. For services on review, claimant's counsel is entitled to an assessed fee of $500, to be paid by the insurer.

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[1] Claimant is not entitled to an attorney fee for services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

In the Matter of the Compensation of
MARTHA D. MARTINEZ, Claimant
WCB Case No. 98-05015
ORDER ON REVIEW
Adams, Day, Kangas & Vaneaton, Claimant Attorneys
Bruce A. Borhholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that assessed a $3,500 attorney fee for services at hearing. SAIF also moves for remand. In his brief, claimant asserts that SAIF's appeal is frivolous. On review, the issues are remand, attorney fees and sanctions.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.[1]

The issue at hearing was whether claimant had established compensability of her low back condition. With regard to an attorney fee, the ALJ indicated he had considered claimant's attorney's affidavit of attorney fees and, based on the affidavit and the factors set forth in OAR 438-015-0010(4), he concluded that $3,500 was a reasonable attorney 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)."

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.

In the present case, even if we assume that the ALJ's findings in this case are inadequately explained, 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.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

[1] We modify the ALJ's order to show that Exhibits 15a, 15b, 30, 31 and 32 were also admitted into evidence.

The issue at hearing was compensability of claimant's low back condition. According to claimant's attorney's affidavit of attorney fees, he spent 21 hours on this claim, not including the actual hearing. The hearing lasted two hours. Claimant testified on her own behalf. The record contains approximately 60 exhibits, 27 of which were generated or submitted by claimant's attorney. There were no depositions.

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. Because claimant's low back condition 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's affidavit of attorney fees), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

In her brief, claimant asserts that SAIF's appeal appears to be frivolous. ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

Based on the Supreme 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. Although SAIF's argument on review did not ultimately prevail, we cannot say it was "frivolous." Accordingly, we deny claimant's request for sanctions.

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, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated October 6, 1998 is affirmed. Claimant's request for sanctions is denied.

In the Matter of the Compensation of
RICHARD R. RINEHART, Claimant
WCB Case No. 97-09974
ORDER ON REVIEW
Charles Woods, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's right shoulder injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the employer as a school bus mechanic. On July 3, 1997, he felt pain in his right shoulder when he caught the weight of a heavy brake drum with his right hand. Claimant filed an injury claim which was denied.

On April 23, 1998, Dr. Puziss performed bilateral arthroscopic shoulder surgery. Claimant's post-operative right shoulder diagnoses were impingement with calcific rotator cuff tendinitis, anterior reactive synovitis, severe rotator cuff tendinitis bursal side, and torn anterior superior labrum.

The ALJ concluded that claimant established that his July 1997 work injury was a material cause of his right shoulder condition, based[1] on Dr. Puziss' opinion.[2]

Dr. Puziss opined that the 1997 work injury, not idiopathic factors or "any previous injury," caused claimant's right shoulder subacromial bursitis, impingement, and torn labrum. (Ex. 39-1). This opinion is based in part on a belief that a prior right shoulder injury (in 1988), resolved "rapidly, without any sequelae whatsoever[]" and that claimant "had no problems at all" prior to his July 1997 work injury. (*Id; see* Ex. 20-2). But claimant did not recover rapidly from his June 29, 1988 back and right shoulder strain injury.[3] On the contrary, his right shoulder condition remained "chronic" in November 1989, with reduced range of motion and lost strength. (Exs. 4-2-3, 4; *compare* Ex. 20-2).

The record does not indicate that claimant had right shoulder problems after 1989, until 1997, except that a transmission fell on his right shoulder in 1994 or 1995 and claimant managed to keep working. (Tr. 14-15, 25-27). No medical report mentions the transmission incident. In any event, considering Dr. Puziss' inaccurate perception of claimant's 1988 injury, we cannot say that the doctor's causation opinion is based on an accurate and complete history.

In addition, we note that 1997 x-rays revealed that claimant had a "huge" calcium deposit in the supraspinatus area of his right rotator cuff (with impingement). (Exs. 20-2; *see* Ex. 25-1). This condition probably combined with claimant's July 1997 injury (at least initially) to cause his subsequent disability and need for treatment. (*See* Exs. 20-2, 26-4-5, 32-4-7, 38-3; *see also* Exs. 29, 30). Thus, the major contributing cause standard of ORS 656.005(7)(a)(B) is applicable.

Dr. Puziss did not distinguish claimant's preexisting condition as a medically separable condition or explain the extent of its contribution as compared to that of the work injury.[4] (*See* Exs. 29; 34-1; 39). Under these circumstances, we find Dr. Puziss' opinion inadequately explained and unpersuasive. *See*

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[1] We acknowledge the employer's contention that the ALJ erred in considering Exhibit 39, an August 26, 1998 (post-hearing) opinion letter from Dr. Puziss, treating surgeon. The employer argues that the ALJ exceeded the range of proper discretion in considering the letter, because the record remained open after hearing only to receive Dr. Puziss' surgery report and subsequent reports from Drs. Scheinberg and Schilperoort, examining physicians, (Exs. 37, 38). In any event, the employer notes that neither the record nor the Opinion and Order indicate that Exhibit 39 *was* admitted.

We are not persuaded that the ALJ kept the record open for a definitely limited purpose. (*See* Tr. 52-53). Therefore, we are inclined to find that Exhibit 39 was admitted at the hearing. Nonetheless, we need not definitively resolve the issue because the disputed exhibit does not change the result.

[2] The ALJ reasoned that Dr. Puziss opinion relating claimant's right shoulder problems to the work injury was a more likely explanation for claimant's labral tear than Dr. Schilperoort's opinion that the injury could not have caused the tear. We find Dr. Puziss' opinion unpersuasive, as explained herein.

[3] The 1988 injury claim was settled by stipulation. (Ex. 6). Claimant's then-treating chiropractor warned that degenerative changes would be likely, "even with guarded usage." (Ex. 4-4).

[4] We note that Dr. Puziss also operated on claimant's "uninjured" left shoulder. He opined that long term overuse, aging factors, and overuse related to right shoulder problems caused claimant's *left* shoulder condition. (Ex. 31).

Dietz v. Ramuda, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Accordingly, in the absence of persuasive evidence supporting the claim,[5] we conclude that claimant has not carried his burden under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated September 17, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

[5] Dr. Verzoza provides the only other medical opinion arguably supporting the claim. But Dr. Verzoza was under the mistaken impression that claimant had no right shoulder problems before the 1997 work incident and her opinion is therefore unpersuasive. (*See* Exs. 12-2; 12-4).

January 28, 1999 Cite as 51 Van Natta 175 (1999)

In the Matter of the Compensation of
EDWARD C. SPENCE, JR., Claimant
WCB Case No. 96-06806
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) directed it to pay 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of claimant's right forearm, as awarded by an Order on Reconsideration; and (2) assessed a penalty for its allegedly unreasonable failure to pay that compensation. In his brief on review, claimant requests additional penalties and sanctions under ORS 656.390 for the self-insured employer's allegedly frivolous request for review. On review, the issues are enforcement, penalties, and sanctions.

We adopt and affirm the order of the ALJ and decline to impose sanctions or additional penalties, as explained below.

Claimant is not entitled to an additional penalty on review, because we may only assess one 25 percent penalty based on a single "amount then due." *See Anthony J. McKenna*, 49 Van Natta 97, 103 (1997); *Laurie A. Bennion*, 45 Van Natta 829 (1993).

We turn to claimant's request for sanctions against the employer's attorney for a frivolous request for review. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2).

The employer has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the employer's argument on review did not ultimately prevail, we cannot say it is "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

Claimant's attorney is entitled to an assessed fee for services on review regarding the enforcement 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 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. Finally, we note that claimant is not entitled to an attorney fee for services devoted to the penalty and sanction issues. *See Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated August 4, 1998 is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
CURTIS R. STEPHENS, Claimant
WCB Case No. 98-04682
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order affirming an Order on Reconsideration that affirmed a Notice of Closure that awarded no scheduled or unscheduled permanent disability. On review, the issues are scheduled and unscheduled permanent disability.

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

Considering the opinion of the attending physician at claim closure (Dr. Smith) and the medical arbiter (Dr. Bald), the ALJ found that claimant had not proved that he had sustained injury-related permanent impairment with regard to his compensable left hip strain. On review, claimant contends that the ALJ's finding is incorrect and that Dr. Bald's arbiter's report established the presence of permanent impairment. Claimant specifically cites Dr. Bald's statement that "claimant has a very definite limitation related to the repetitive use of his left hip that is felt to be a direct result of the accepted condition." (Ex. 63-5).

Dr. Bald also stated, however, that claimant's left hip injury and subsequent femoral neck fracture were the major contributing cause of his current hip pain, restricted range of motion and limitations related to use. *Id.* As the ALJ noted, the femoral neck fracture is not a compensable condition because a prior ALJ affirmed the employer's denial of that condition. (Exs. 47, 62).

Accordingly, we agree with the ALJ that Dr. Bald's failure to differentiate permanent impairment from the compensable and noncompensable conditions precludes an award of permanent disability based on the arbiter's report. Because we agree with the ALJ that the remainder of the record does not support a finding of injury-related impairment, we agree with the ALJ's decision to affirm the Order on Reconsideration.[1]

ORDER

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

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[1] Claimant requests that "remand" this matter for a rating of disability according to the medical arbiter's report. It is not clear what relief claimant is requesting because the arbiter's report was considered by the ALJ and has also been considered on review. We find no compelling reason to remand. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

In the Matter of the Compensation of
WALLACE W. WACKER, Claimant
WCB Case Nos. 98-02624 & 98-00475
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On January 19, 1999, the Board affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's occupational disease claim for a thoracic disc syndrome condition; and (2) upheld the insurer's denial of claimant's aggravation claim for the same condition. The parties have now submitted a proposed "Disputed Claim Settlement," which is intended to resolve the compensability of claimant's denied aggravation claim, as supplemented in the agreement.[1]

Pursuant to the settlement, claimant stipulates that the insurer's denial, as supplemented in the agreement, "shall forever remain in full force and effect." The settlement further provides that claimant's "Request for Hearing shall be dismissed with prejudice."

In submitting the settlement for approval, the parties have also represented that their agreement "will dispose of all issues before [the Board] on review, and the matter may be dismissed." Inasmuch as one of the issues on review concerns the compensability of claimant's original occupational disease claim for thoracic disc syndrome and because the settlement is designed to resolve the compensability of claimant's aggravation claim for claimant's *current* thoracic condition (and expressly provides that claimant retains his rights insofar as they might be related to his original accepted claim), we interpret the parties' intention to be that the insurer has withdrawn its request for Board review of the ALJ's order that found claimant's original occupational disease claim to be compensable. This interpretation is further confirmed by the parties' other settlement that has received ALJ approval, which resolved a compensability dispute regarding claimant's current thoracic condition that arose from claimant's occupational disease claim that the previous ALJ and this Board had found compensable.

Accordingly, we withdraw the Board's January 19, 1999 order. On reconsideration, we have approved the parties' settlement, thereby resolving their dispute. Consequently, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] The parties also submitted another "Disputed Claim Settlement," which provides for the resolution of a compensability dispute regarding "claimant's current thoracic spine condition, including thoracic disc syndrome and degenerative disc disease" that was pending before the Hearings Division. (WCB Case No. 98-07228). That settlement, which pertains to a dispute arising from the insurer's processing of claimant's occupational disease claim that had been found compensable by the ALJ's order in this case and affirmed by our initial order, has received ALJ approval, thereby also fully and finally resolving the issues that were pending before the Hearings Division.

In the Matter of the Compensation of
DANIEL COUVILLION, Claimant
Own Motion No. 98-0518M
OWN MOTION ORDER

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable degenerative medial and lateral meniscus tear of the right knee. Claimant's aggravation rights expired on July 23, 1997. The employer asks the Board to authorize the reopening of claimant's claim.[1]

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

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

The employer contends that claimant was retired at the time of the current disability and therefore not in the work force. The employer has not responded to the Board's December 29, 1998 correspondence seeking clarification of the work force issue. Furthermore, claimant has not responded to the Board's inquiry nor to the employer's contention.[2] Claimant has the burden of proof on this issue and must provide evidence on that issue (*e.g.*, copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question).

The information submitted to us to date does not demonstrate claimant's presence in the work force at the relevant time. While payment of medical benefits is not in dispute, claimant's request for temporary disability compensation is nevertheless denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] With its recommendation, the employer requested authorization from us to reopen claimant's claim "as soon as possible so the surgery date does not need to be changed." However, the employer contended that the claim would not need to be reopened for temporary disability benefits because claimant is retired.

[2] The December 29, 1998 letter from the Board also granted claimant an opportunity to provide evidence demonstrating that he was in the work force. The Board requested a response be submitted 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.

In the Matter of the Compensation of
CAROLYN EGAN, Claimant
WCB Case No. 98-01100
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

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

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

Relying on the medical opinions of claimant's attending physicians, Drs. Humphrey and Stringham, the ALJ set aside the insurer's denial of claimant's low back injury claim. On review, the insurer contends that those medical opinions are not persuasive because they are conclusory and based on an inaccurate history. We disagree.

The insurer primarily disputes the persuasiveness of Dr. Stringham's opinion based on an allegation that Dr. Stringham incorrectly assumed that claimant's low back and leg symptoms appeared three or four days after an October 31, 1997 incident at work; whereas, according to the insurer, claimant's symptoms did not appear until a week after the alleged incident.

At his deposition, however, Dr. Stringham indicated that he was familiar with the history the insurer alleges is accurate. (Ex. 15-7, 15-13). Nevertheless, Dr. Stringham concluded that the October 31, 1997 incident was the major contributing cause of claimant's L5-S1 disc herniation. (Ex. 15-21). Because Dr. Stringham's opinion was based on complete and accurate information and was tested at a deposition, we agree with the ALJ that it is persuasive. *Somers v. SAIF*, 77 Or App 259 (1986).

Dr. Humphrey provided claimant's initial treatment and received a history that claimant's leg pain did not begin until a week after the alleged October 31, 1997 incident. (Exs. 1-1, 7). Dr. Humphrey opined, based on reasonable medical probability, that the October 31, 1997 work activity was the major contributing cause of claimant's back injury. (Ex. 13). Dr. Humphrey agreed that the mechanism of injury was consistent with the injury sustained and that there were objective findings both clinically and in imaging studies. (Ex. 13). We find Dr. Humphrey's opinion to be well-reasoned and based on a complete and accurate history. We find that it, too, is persuasive.

In summary, we conclude that the medical evidence on which the ALJ relied establishes that the October 31, 1997 incident was the major contributing cause of claimant's low back condition. We, therefore, affirm.

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

ORDER

The ALJ's order dated September 18, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
LESTER GUYSE, Claimant
WCB Case No. 98-04031
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a mental disorder (acute stress reaction). On review, the issue is compensability.

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

Claimant, age 59 at the time of hearing, worked as an armed security guard in the employer's cash vault. He was stationed in a concrete reinforced, bullet proof glass enclosed room with electrically locking doors. His duties included controlling access to the bank's vault through an area known as a "man trap," a double locked gate.

On March 2, 1998, claimant received a call from the manager of the bank's security department. The manager, who was located in San Francisco, told claimant that there was a problem with the security background check of a newly hired guard (Kelly), and asked claimant to cover that guard's shift the next day. The manager also told claimant that, when Kelly arrived for his shift, he was to advise Kelly of the problem and not issue Kelly his weapon. Claimant knew that Kelly had an interest in guns, and claimant was apprehensive about telling Kelly that he could not wear his weapon. Claimant also believed that Kelly had a criminal conviction for assault.

Claimant arrived at work the next morning a little after 6 a.m. After arming himself, he put the key to the gun safe in the security room in his pocket, as he had been advised to do by the manager. Kelly arrived around 6:25 a.m. When Kelly noticed that the key had been removed from the gun safe's lock, claimant told him that there was a problem with his background check and that he could not wear his weapon. This information set Kelly off into an angry tirade.

Although Kelly did not physically threaten or assault claimant, he was very angry and upset. Kelly ranted and raved about not being issued his weapon and being discriminated against by other bank employees because of his race. During this time, claimant remained in the security room with Kelly. Claimant told Kelly that he was just relaying the message and was unaware of the problem with the background check. Claimant, afraid of what Kelly might do, attempted to calm Kelly down and defuse the situation.

At some point, Kelly had a conversation with the bank's cash flow manager in the "man trap" of the vault. At another point, Kelly had a heated exchange on the telephone with a security manager in San Francisco. Kelly then handed the phone to claimant, and the manager told claimant that Kelly was to leave the premises. Kelly remained angry and upset. After discussing the situation with claimant a while longer, Kelly calmed down. He left the bank premises about 8:15 a.m; and did not return. Claimant completed his shift.

Later that day, the cash flow manager came into the vault and told claimant that she was pleased with the way he handled the morning's situation. Claimant said he was doing his job, and thought he handled the problem well.

Claimant returned to work the day after this incident, but over the next few weeks, he began to experience anxiety attacks. At first, they were of no consequence, but they grew gradually worse, occurring several times a week. Claimant felt depressed and had trouble sleeping. On about March 18, 1998, he had a debilitating anxiety attack at work, where he felt like he was in an almost catatonic state.

On March 20, 1998, claimant sought treatment complaining of work-related stress. He told Dr. Peacock about the incident on March 3, 1998 and some other frustrating incidents at work. Dr. Peacock diagnosed an acute stress reaction, started claimant on Paxil and referred him to Dr. Lange.

Claimant saw Dr. Lange on March 23, 1998, and again described the March 3, 1998 incident and other events at work. Dr. Lange diagnosed adjustment disorder with symptoms of anxiety and depression. He opined that claimant's condition was related to the threatening situation at work, and should resolve in time.

Claimant was examined by Dr. Turco on April 29, 1998. Dr. Turco opined that claimant reacted to the situation involving Kelly in an extreme fashion and developed an acute stress disorder/adjustment disorder with mixed emotional features. Dr. Turco further noted that claimant was being appropriately treated and should sustain no permanent impairment. In a supplemental report, Dr. Turco concluded that claimant was a very sensitive person, and that his perception of the situation involving Kelly created the acute stress reaction.

The ALJ found that claimant had established a compensable mental disorder under ORS 656.802(3). On review, the employer argues that although claimant has a diagnosis of a mental disorder, he has not shown that: (1) the employment conditions allegedly producing the mental disorder exist in a real and objective sense; (2) the employment conditions are not generally inherent in every working situation; and/or (3) his mental disorder arose out of and in the course of his employment. *See* ORS 656.802(a), (b) and (d). Like the ALJ, we find to the contrary.

In deciding if the employment conditions exist in a real and objective sense, we determine whether the events underlying claimant's mental condition are real, as opposed to imaginary, and are capable of producing stress. *Duran v. SAIF*, 87 Or App 509, 513 (1987). This question does not include whether claimant's perception of the events is reasonable or not, because the medical effect of the events is measured by the actual reaction rather than by an objective standard of whether the conditions would have caused disability of an average worker. *Peterson v. SAIF*, 78 Or App 167, 170, *rev den* 301 Or 193 (1986).

Here, it is undisputed that claimant was involved in a tense and unusual situation involving Kelly. Claimant had been directed to tell Kelly there was a problem with his background check and not issue Kelly a weapon. Kelly became angry and agitated, and claimant had to remain in the cash vault security room with him while attempting to defuse the situation. Although this type of encounter may not have affected other persons the way it affected claimant, the incident did in fact occur. In other words, claimant's perception of the situation was based on real events which were capable of causing stress. Therefore, claimant has satisfied the "real and objective" requirement of ORS 656.802(3)(a).

The next question is whether the events leading to claimant's anxiety reaction are conditions other than conditions generally inherent in every working situation. The phrase "generally inherent in every working situation" means those conditions that are usually present in all jobs and not merely in the specific occupation involved. *See, e.g., Merry J. Morgans*, 47 Van Natta 147 (1995). Here, like the ALJ, we find the situation that existed in the cash vault security room involved conditions other than those generally inherent in every working situation. Claimant, an armed guard, had to tell Kelly he could not have his weapon. Claimant then had to deal with Kelly's angry tirades, calm Kelly down and ensure that he leave the bank premises without further incident. This nearly two-hour, emotionally-charged encounter with Kelly goes beyond the type of interpersonal conflict and/or personality clashes between co-workers that we have found to be generally inherent in every working situation. *Compare Lynn A. Horton*, 45 Van Natta 2203 (1993); *Gregory L. Brodell*, 45 Van Natta 924 (1993).

Finally, on this record, we find clear and convincing evidence that claimant's mental disorder arose out of and in the course of his employment. The employer admits that, in preventing Kelly from wearing his weapon and dealing with a potentially threatening situation, claimant was doing the very job he had been directed to do by management. All three doctors who evaluated claimant concluded that the situation with Kelly created claimant's acute stress reaction. Dr. Turco reported that the March 3, 1998 incident was the major cause of claimant's mental disorder because it was the focus of his difficulties. Dr. Turco could find no other circumstance that was producing claimant's anxiety. We therefore agree with the ALJ that claimant has established a compensable mental disorder claim under ORS 656.802(3).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 14, 1998 is affirmed. For services on review, claimant's counsel is awarded $1,250, payable by the employer.

In the Matter of the Compensation of
HAROLD A. MORTON, JR., Claimant
WCB Case No. 98-03070
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
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 partial denial of claimant's injury claim for a right shoulder acromial clavicular (AC) joint arthritis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked for the employer as a forklift driver, beginning in April 1996. On April 28, 1997, he compensably injured his right shoulder pulling on boards over his head. He felt immediate pain and his shoulder became swollen. Claimant sought treatment the next day. Dr. Jacobson operated on claimant's right shoulder twice.[1]

SAIF accepted claimant's right shoulder subacromial bursitis and rotator cuff tendinitis, but denied "AC joint arthritis." Claimant requested a hearing.

The ALJ upheld SAIF's partial denial of claimant's arthritis condition, because he found Dr. Jacobson's opinion relating that condition in part to claimant's "work activities" inadequate to prove this *injury* claim. The ALJ reasoned that Dr. Jacobson's opinion was based on an inappropriate factual predicate (work activities, rather than the April 28, 1997 event). Finding that no expert opined that the *injury* was a material cause of claimant's arthritis, the ALJ concluded that the claim failed.

Claimant argues that Dr. Jacobson was fully aware that claimant suffered a discrete injury on April 28, 1997 and the doctor's opinion as a whole clearly relates claimant's right shoulder problems to that injury, despite its later references to "work activities."

SAIF responds that the ALJ properly declined to rely on Dr. Jacobson's opinion because the doctor never referred to the April 28, 1997 work incident. In addition, SAIF argues that Dr. Jacobson's opinion is not persuasive because he failed to consider the causal contribution from claimant's undisputed preexisting right shoulder degeneration.

We find the claim compensable, based on the following reasoning. First, to the extent that claimant's post-injury work activities contribute to his condition, they do not weigh *against* his claim. Nonetheless, we agree with the parties and the ALJ that this claim is properly analyzed as an injury under ORS 656.005(7)(a), because the initial disability and need for treatment arose suddenly, during a

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[1] Claimant returned to modified work after his September 28, 1997 right shoulder surgery. His modified work involved monitoring chipper operation, but it also required swinging a sledgehammer with his left hand and using his left upper extremity to operate a pry bar. Claimant's right shoulder symptoms increased. Dr. Jacobson performed a second right shoulder surgery on February 19, 1998.

discrete time period, and the work injury remains the primary cause of claimant's need for treatment.[2] Therefore, claimant must establish that his injury was a material cause of his right shoulder arthritis or, if his preexisting degeneration combined with the injury to cause his condition, that the injury was the major contributing cause of the condition or the disability and/or need for treatment for the condition. *See* ORS 656.005(7)(a)(B).[3] We find that Dr. Jacobson's opinion persuasively supports the claim, whether claimant's arthritis (defined as inflammation) is analyzed as a condition separable from his preexisting degeneration, or as a combined condition.

Dr. Jacobson differentiated between claimant's preexisting degeneration and his arthritis. (*See* Exs. 20, 36B-1). He described the latter as an inflammatory process related to claimant's work -- which he variously described as "activities" and "injuries." (*Id*). The distinction between the preexisting degenerative condition and the arthritis condition (the latter causing the need for treatment) is consistent with claimant's history of no prior shoulder problems, followed by ongoing post-injury problems, including those after the first surgery (when claimant returned to work). In our view, Dr. Jacobson's opinion is well-reasoned and consistent with claimant's history. The persuasiveness of Dr. Jacobson's opinion is not diminished by references to work activities or injuries (plural), because the doctor was clearly aware of the timing and import of the 1997 work injury, (*see* Exs. 8, 20, 27), claimant's lack of prior problems, and the specific character of the right shoulder condition, which he observed firsthand twice during surgery.

Dr. Scheinberg offers the only contrary medical evidence. He reviewed claimant's records and opined that claimant's "degenerative arthritic changes" preexisted the April 1997 work injury. (Ex. 35-5). He found no evidence that the injury "worsened" the preexisting condition. (Ex. 35-6). But Dr. Scheinberg did not address Dr. Jacobson's opinion that the *inflammatory* arthritic component was the condition treated by the surgeries, nor did he rebut Dr. Jacobson's conclusion that claimant's "work injuries" caused the right shoulder condition. Accordingly, based on Dr. Jacobson's well-reasoned opinion, and considering Dr. Jacobson's particular advantage as claimant's treating surgeon, we conclude that the claim is compensable.[4] *See Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988).

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

ORDER

The ALJ's order dated August 12,1998 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 $5,000 attorney fee, payable by SAIF.

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[2] *See Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984) (the claimant's back trouble coincided with jolting of the faulty loader; the fact that it grew worse over his subsequent employment did not make it "gradual in onset"); *Olive B. Lyons*, 48 Van Natta 1887 (1996).

[3] *See SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997).

[4] We would reach this conclusion even if the standard is "major contributing cause" under ORS 656.005(7)(a)(B). In this regard, we note that Dr. Jacobson considered and distinguished claimant's preexisting degeneration in evaluating claimant's need for right shoulder treatment.

In the Matter of the Compensation of
ANNA TATE, Claimant
WCB Case No. 98-05156
ORDER ON REVIEW
Cole, Cary, 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) Brazeau's order that affirmed an Order on Reconsideration that awarded 16 percent (51.2 degrees) unscheduled permanent disability for a myofascial pain syndrome condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

At the time of her injury, claimant was working as a housekeeper for a hospital. Claimant's compensable conditions are bilateral carpal tunnel syndrome (CTS) and myofascial pain syndrome. On January 21, 1998, the insurer accepted claimant's myofascial pain syndrome claim pursuant to a prior ALJ's order finding that condition compensable. As a result of this acceptance, the insurer reopened claimant's claim. It is the closure of that claim that is now before us.

On April 14, 1997, Dr. Hill, claimant's attending physician, found claimant capable of medium-duty work and felt that she could return to full-time house cleaning if the myofascial pain syndrome was her only condition. (Ex. 22-1). Based solely on the myofascial pain syndrome, Dr. Hill opined that claimant had a weight lifting restriction of 50 pounds maximum, could lift up to 20 pounds frequently and up to 50 pounds occasionally. But secondary to her noncompensable fibromyalgia condition, Dr. Hill found claimant limited to sedentary or, possibly, light duty work. (Ex. 22-2).

On February 2, 1998, Dr. Hill stated that he had found claimant was medically stationary regarding her CTS and myofascial pain syndrome as of March 17, 1997, and continued to be of that opinion. (Ex. 28). He also stated that as of March 17, 1997, claimant could return to her full-time custodial duties regarding the CTS and myofascial pain syndrome. But he felt that claimant was unable to return to those duties due to her noncompensable fibromyalgia condition. (*Id.*).

On March 23, 1998, Dr. Hill performed a closing exam at the insurer's request. (Ex. 31). He found that claimant had permanent work restrictions related to the compensable myofascial pain syndrome that included maximum lifting of 50 pounds with only occasional lifting greater than 20 pounds. (Ex. 31-2). No other restrictions related to the myofascial pain syndrome. Regarding the noncompensable fibromyalgia condition, however, he found claimant limited to sedentary work only. (*Id.*). There is no evidence that the job claimant held at the time of injury was available.

On April 16, 1998, the insurer issued a Notice of Closure closing claimant's claim and declaring her medically stationary as of March 17, 1997. (Ex. 33). This Notice of Closure awarded 6 percent unscheduled permanent disability, which represented claimant's impairment due to her myofascial pain syndrome. The insurer made no award for non-impairment factors.

Claimant requested reconsideration, raising only the issue of age, education, and adaptability. (Ex. 34). On June 17, 1998, an Order on Reconsideration awarded claimant 16 percent unscheduled permanent disability, which consisted of 6 percent impairment and 10 percent non-impairment (age, education, and adaptability). (Ex. 35). The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The only issue at hearing and on review is whether claimant is entitled to social/vocational values for age, education and adaptability in rating her unscheduled permanent disability for her compensable myofascial pain syndrome condition.[1] The ALJ determined that, regarding the myofascial

[1] Neither party disputes the 6 percent impairment value awarded by the Notice of Closure and affirmed by the Order on Reconsideration and the ALJ. (Exs. 33, 35).

pain syndrome condition, claimant had not been released to regular work by Dr. Hill, her attending physician. In reaching this conclusion, the ALJ compared claimant's Base Functional Capacity (BFC) to her Residual Functional Capacity (RFC) at the time she was medically stationary. *Former* OAR 436-035-0310(1).[2] The ALJ determined that claimant's BFC was "medium" in reliance on the strength value assigned to the job of "housekeeper, hospital" in the *Dictionary of Occupational Titles* (DOT). (DOT 323.687-010). *Former* OAR 436-035-0310(4). The ALJ also calculated claimant's RFC relating to her myofascial pain syndrome condition as "medium/light," which is less than her BFC of "medium" relating to that condition. Therefore, the ALJ found that claimant was unable to perform her "regular" work. Thus, the ALJ concluded that claimant was entitled to social/vocational values.

Relying on Dr. Hill's April 14, 1997 and February 2, 1998 reports, the insurer argues that claimant was released to her regular work at her at-injury job. (Exs. 22, 28). Furthermore, the insurer argues, ORS 656.726(f)(D)(ii)[3] and *former* OAR 436-035-0270(3), which applies ORS 656.726(3)(f)(D), control and preclude any award for social/vocational factors in rating unscheduled disability because claimant was released to her regular work. Moreover, the insurer argues that the ALJ erred in applying *former* OAR 436-035-0310 and relying on the DOT to determine claimant's BFC. The insurer contends that *former* OAR 436-035-0310 does not come into play until it is established that ORS 656.726(3)(f)(D) does not apply. Finally, the insurer argues that, if it is found that *former* OAR 436-035-0310 must first be applied to determine whether social/vocational factors may be considered, the rule is inconsistent with ORS 656.726(3)(f)(D) and, therefore, must be found invalid.

In response, claimant makes several arguments as to why the insurer's reliance on Dr. Hill's April 14, 1997 and February 2, 1998 reports is misplaced. In the alternative, claimant argues that ORS 656.726(3)(f)(D)(ii) does not apply because there is no evidence that claimant's job at injury was available. Because we agree with claimant's alternative argument, we need not address the parties' other arguments.

ORS 656.726(3)(f)(D)(ii) provides that impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if the "attending physician releases the worker to regular work at the job held at the time of injury *and the job is available* but the worker fails or refuses to return to that job[.]" (Emphasis added). Thus, three factors must be established under ORS 656.726(3)(f)(D)(ii) before that statute applies to restrict disability to the impairment factor: (1) the attending physician must release the worker to regular work at the job held at injury; (2) that job must be available; and (3) the worker must fail or refuse to return to that job.

The insurer contends that Dr. Hill's opinions establish that he released claimant to her regular at-injury job but claimant failed to return to that job due to her noncompensable medical conditions. Nevertheless, even if we agree with the insurer's contentions, they only establish the first and third factors of ORS 656.726(3)(f)(D)(ii). Dr. Hill's opinions do not establish that the at-injury job was available, nor does any other evidence in the record establish that factor. Thus, the second factor is not met.

ORS 656.726(3)(f)(D)(ii) applies only if its terms are met. We may not "assume" that claimant's at-injury job was available when she was released to "regular work." Under these circumstances, we conclude that ORS 656.726(3)(f)(D)(ii) does not apply to this case. *See Manuel G. Dimas*, 48 Van Natta

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[2] Claimant's permanent disability is determined by evaluating her condition as of the date of the Order on Reconsideration using the disability standards in effect as of the date of claim closure. ORS 656.268(7); 656.295(5); OAR 436-035-0003(2) and (3). Here, the applicable standards are found in WCD Admin. Order 96-072 (eff. 2/15/97).

[3] ORS 656.726(f) provides:

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

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury by the worker's employment is terminated for cause unrelated to the injury."

2577 (1996) (ORS 656.726(3)(f)(D)(ii) does not apply where the claimant was released to regular work but the record was insufficient to establish that the at-injury job was available). Nor do ORS 656.726(3)(f)(D)(i) or (iii) apply to this case. In this regard, claimant did not return to regular work at the job at injury, nor is there any evidence that she was terminated for cause unrelated to the injury. Because ORS 656.726(3)(f)(D) does not apply, claimant's disability is not limited to her impairment. Thus, claimant is entitled to social/vocational values in calculating her unscheduled permanent disability.

We adopt the ALJ's calculation of claimant's BFC as "medium" and her RFC as "medium/light," which results in an adaptability factor of 2. *Former* OAR 436-035-0310. The parties do not dispute the values of claimant's age (1) and education (4) factors. These factors are added for a total of (5), which is multiplied by the adaptability factor (2) for a total social/vocational value of (10). That total is added to claimant's impairment value (6), which results in 16 percent unscheduled permanent disability. *Former* OAR 436-035-0280.

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

ORDER

The ALJ's order dated September 30, 1998 is affirmed. For services on review, claimant's attorney is awarded a fee of $2,000, payable by the insurer.

In the Matter of the Compensation of
RORY K. OLSON, Claimant
WCB Case No. C8-02993
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

On December 24, 1998 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on December 24, 1998. The statutory 30th day following the submission is January 25, 1999. Claimant filed his request for disapproval of the disposition on January 25, 1999. Accordingly, we disapprove the disposition. *Id.*

It does not appear that the parties were provided with claimant's request for disapproval, we are now providing the parties with a copy.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

The parties may move for reconsideration of the Board order 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
JOSHUA C. BATES, Claimant
WCB Case No. 98-01329
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's claim for multiple injuries sustained in a motor vehicle accident; (2) assessed a 25 percent penalty for an allegedly unreasonable denial; and (3) assessed a $4,000 attorney fee for services at hearing. On review, the issues are compensability, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 20 at the time of hearing, worked for the employer as a heavy equipment repair mechanic. On Saturday, July 19, 1997, claimant spent the morning working at the employer's shop. The owner left the shop about noon for a personal appointment. After the owner left, one of the employer's customers, Crown B, called and requested service on a bale wagon on its property. Mr. Bishop, who was responsible for service calls in the owner's absence, took the call and agreed to service the baler that afternoon.

After claimant clocked out, he asked Bishop his plans for the afternoon. Bishop advised claimant that he was going to lunch then out to Crown B to repair a slave cylinder on a bale wagon. Claimant asked if he could go along with Bishop. Bishop said sure and offered to buy claimant lunch.

Bishop and claimant left the employer's shop in Bishop's truck. They stopped for lunch. After lunch, they drove to Crown B, where Bishop diagnosed the problem with the bale wagon. Bishop and claimant then went into town, obtained the necessary parts for the repair and returned to Crown B.

Although Bishop did most of the work, claimant assisted with the repair. At one point, claimant sat in the bale wagon's cab and pumped the clutch pedal to bleed the hydraulic line. He also handed tools to Bishop and examined the drive line. Once the bale wagon was operational, Bishop and claimant left Crown B.

As Bishop and claimant were returning to the employer's shop, Bishop's truck was struck by another vehicle. Claimant suffered multiple injuries, including a severe head/brain injury. He was temporarily totally disabled and required extensive medical treatment due to his injuries.

The employer permitted Bishop to use his truck for service calls and reimbursed Bishop for gas. Although neither claimant nor Bishop submitted the time spent on the Crown B service call to the employer, the employer would have paid wages had they done so. It was common for employees headed out on service calls to "clock out" from the shop as they left and later add the hours spent on the call to their time slip.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's injuries occurred within the course and scope of his employment and were therefore compensable. In addition, the ALJ concluded that SAIF had no legitimate doubt as to the compensability of the claim, and assessed a penalty under ORS 656.262(11).

On review, SAIF argues that claimant was not working when he was injured in the motor vehicle accident. We disagree, and adopt and affirm the ALJ's determination that claimant's injuries arose out of and in the course of his employment. But, with regard to the penalty award, we agree with SAIF that it had a legitimate doubt regarding its liability for claimant's injuries. We therefore reverse that portion of the ALJ's order.

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). As noted above, 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.*

Because "course and scope" cases tend to turn on their own particular facts, reasoning by analogy to previous cases is of limited value. *See, e.g., Benafel v. SAIF*, 33 Or App 597, 599 (1978) (*citing Casper v. SAIF*, 13 Or App 464, 470 (1973)). Compensability of an injury depends on whether, considering all relevant factors, the activity causing the injury was sufficiently connected to work. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994); *see also Andrews v. Tektronix, Inc.*, 323 Or 154, 159-160 (1996) (the "arising out of" and "in the course of" employment prongs serve as analytical tools for determining whether there is a sufficient connection between the employment and the injury to warrant compensation).

Here, we find that, considering the "totality of circumstances" surrounding claimant's injury, SAIF had a reasonable doubt regarding its liability for the claim. Although we are satisfied that there is a sufficient connection between claimant's injuries and his employment to uphold the finding of compensability, we recognize that claimant had "clocked out" and did not expect to be paid for his participation in the service call at Crown B. Because claimant's injury occurred as he was returning to the employer's premises but at a time when he was not scheduled or expected to be working, SAIF's liability was not clear cut. Indeed, as SAIF notes, even though claimant undertook to assist Mr. Bishop in good faith to advance the employer's interests, not every act which benefits the employer is in the course of employment. *See, e.g., Dave G. Owen*, 43 Van Natta 2680 (1991). Consequently, we disagree with the ALJ's conclusion that SAIF's denial was unreasonable.

We next turn to SAIF's contention that the ALJ failed to provide a sufficient explanation for the assessed attorney fee. As we explained in *Daryl L. Underwood*, 50 Van Natta 2330 (1998), an ALJ is not required to make specific findings regarding the factors set forth in OAR 438-01500010(4) where, as here, there is no specific attorney fee requested and the parties did not submit arguments addressing the factors to be weighed in determining a reasonable fee. The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, because the ALJ simply ordered SAIF to pay $4,000 and did not indicate that she applied the rule-based factors in determining the fee amount, we agree that the ALJ's reasoning is insufficient. Nevertheless, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary for us to remand the case to the ALJ for supplementation of findings on this issue. *See Darryl L. Underwood*, 50 Van Natta at 2332.

As noted above, claimant's attorney did not submit a statement of services showing the time devoted to the case. A hearing convened that lasted approximately three-and-a-half hours. Claimant and the employer's owner testified, and the transcript consists of 93 pages. The record consists of 21 exhibits, 13 of which were submitted by claimant's attorney.

Based on compensability disputes generally litigated before this forum, we find the compensability/course and scope issues involved in this case to be of above average complexity. The value of the interest and benefit secured were significant, in that claimant's injuries were serious and required extensive treatment. Furthermore, considering the fact-driven course and scope law, there was a risk that claimant's attorney might go uncompensated. Finally, the attorneys involved in this case are skilled litigators with substantial experience in workers' compensation law.

Based on these factors, especially the complexity of the issues, the value of the interest involved and the risk that claimant's attorney might go uncompensated, we agree with the ALJ that $4,000 is a reasonable attorney fee.

Because SAIF continued to contest compensability on review, claimant's attorney is also entitled to an assessed fee for services on review with regard to the compensability issue.[1] ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 27, 1998 is affirmed in part and reversed in part. That part of the order that assessed a penalty is reversed. The remainder of the order is affirmed. For services on review with regard to the compensability issue, claimant's counsel is awarded $1,300, payable by SAIF.

[1] Claimant is not entitled to an attorney fee on review for his counsel's services regarding the defense of the attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986). Furthermore, claimant is not entitled to an attorney fee for his counsel's services devoted to the penalty issue. *See Saxton v. SAIF*, 80 Or App 631 (1986).

January 29, 1999 Cite as 51 Van Natta 189 (1999)

In the Matter of the Compensation of
WALTER E. JUDISH, Claimant
WCB Case No. 98-03947
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its *de facto* denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in November 1986. (Ex. 1). The insurer accepted an acute lumbosacral strain and a herniated disc at L4-5. (Ex. 2). In late 1986, claimant had a partial hemilaminectomy at L4-5 on the right. (Exs. 5-2, 36). In February 1989, claimant had a decompressive laminotomy at L4-5 on the right. (Ex. 5-3). In March 1989, claimant had a right L4-5 laminotomy with disc and nerve root exploration, removal of the disc nucleus fragment and debridement of the nerve root. (Ex. 5-4). A Determination Order issued April 11, 1991, awarding 28 percent unscheduled permanent disability. (Ex. 9).

On October 8, 1991, the insurer issued a denial of claimant's back condition, asserting that the "condition is not related to your industrial claim with [the employer]; but is most likely caused from your landscaping activities." (Ex. 10). The insurer denied compensability and responsibility of claimant's current need for treatment. (*Id.*) Claimant requested a hearing. An Opinion and Order issued on December 31, 1992, setting aside the insurer's denial. (Ex. 13). The insurer appealed the December 31, 1992 Opinion and Order.

In early 1993, claimant's physicians had recommended a far lateral discectomy at L4-5 to decompress the L4 nerve root with a subsequent fusion. (Ex. 15-5). After reviewing a videotape of claimant's activities, however, Drs. Kitchel and Englander no longer recommended surgery. (Exs. 16, 17, 20).

While review of the December 31, 1992 Opinion and Order was pending before the Board, the parties entered in a Disputed Claim Settlement (DCS) on August 17, 1993. (Ex. 21). The DCS indicated that claimant had filed a claim for aggravation of the accepted condition and the insurer had issued a denial on October 8, 1991. (Ex. 21-1). Paragraphs 9 and 10 of the DCS provided that the insurer "herein issues its denial of claimant's current low back condition including radiculopathy at L4 secondary to far lateral disc" and claimant "herein" appealed the denial. (Ex. 21-2). The DCS provided, in part:

"11. A bona fide dispute exists among the parties as to the compensability of claimant's claim for workers' compensation benefits related to his current low back condition and the parties have agreed to compromise and settle the denied and disputed claim according to the provisions of ORS 656.289(4);

"12. The factual allegations and legal positions of the parties may be summarized as follows:

"A. Claimant: Claimant contends that his compensable 1986 injury that occurred while he was employed at [the employer] is the major contributing cause of his current low back condition including L4 radiculopathy secondary to far lateral disc, therefore his claim and current condition remain compensable.

"B. Insurer: [The insurer] contends that claimant had a preexisting disease or condition when he sustained his 1986 compensable injury and that his preexisting disease or condition, together with his 1992 off-work activities are, in combination, the major contributing cause of his current low back condition including L4 radiculopathy secondary to his far lateral disc, therefore his current low back condition, including L4 radiculopathy secondary to his far lateral disc, is not compensable." (Ex. 21-2, -3; underline in original).

The DCS provided that claimant should receive $11,500 and the insurer's denial "as stated above in paragraph 10, including and incorporating the contentions set forth in paragraph 12B above, shall be affirmed." (Ex. 21-3). The DCS also provided that claimant's requests for hearing against the insurer, "including all raisable issues," shall be dismissed with prejudice. (Ex. 21-3, -4).

On October 21, 1993, the Board approved a Claim Disposition Agreement (CDA) that settled "claimant's claim for compensation and payments of any kind, due or claimed, for the past, the present, and the future, except compensable medical services and own motion rights," for a sum of $2,500. (Ex. 22).

On February 7, 1997, claimant sought treatment from Dr. Edmonds, neurologist. Dr. Edmonds reported that claimant was "continuing to have problems with his right foot" after an injury and surgeries. (Ex. 25-1). After examining claimant, Dr. Edmonds concluded that his "symptoms are similar to those which he reported in 1989 through 1993." (Ex. 25-3). Nevertheless, she recommended further testing. Nerve conduction studies by Dr. Edmonds on February 21, 1997 showed mild right posterior tibial neuropathy. (Ex. 27-1). Electromyography on the same date showed "[p]ossible right L5 radiculopathy." (Ex. 27-2). Dr. Edmonds reported that the MRI showed a scar or recurrent disc herniation on the right at L4-5 and she referred claimant to a neurosurgeon. (Ex. 28).

On March 17, 1997, claimant was examined by Dr. Gallo, neurosurgeon. (Ex. 29). Dr. Gallo reported that claimant had an 11-year history of right leg radicular pain that had become more painful over the last two months. (Ex. 29-1). She reported that claimant's recent MRI showed mild to moderate disc degenerative disease at L4-5 with a mild decrease in disc height. (Ex. 29-4). She found no evidence of any recurrent disc herniation at L4-5. (*Id.*) She remarked that claimant had the "same pain he has always had, and the same distribution of numbness, only worse recently." (*Id.*) Dr. Gallo did not recommend surgery.

On May 14, 1997, claimant was examined by Dr. Hacker, neurosurgeon. (Ex. 31). He initially diagnosed failed laminectomy syndrome with chronic low back and right lower extremity pain. (Ex. 31-2). He recommended a lumbar myelogram with a CT follow-up, which were performed on May 28, 1997. (Exs. 32, 33). After reviewing the test results, Dr. Hacker recommended selective nerve root blocks, which were performed by Dr. Karasek. (Exs. 33B-2, 33C, 33D).

On October 3, 1997, Dr. Hacker reported that claimant's myelogram confirmed a far lateral component at L4-5 with compression of the exiting L4 nerve root. (Ex. 34). He recommended a "complete discectomy, thorough decompression, fusion and fixation with BAK via posterior approach at the L4-5 level[.]" (*Id.*) In a later report, Dr. Hacker said that the selective nerve root block confirmed the L4 nerve root as the source of claimant's low back pain. (Ex. 38-1). He concluded that the various tests, as well as claimant's neurological examination showed deficits consistent with an L4 radiculopathy and he continued to recommend surgery. (*Id.*)

On December 23, 1997, claimant was examined by Drs. Williams and Sacamano on behalf of the insurer. (Ex. 36). They found no evidence of a lumbar radiculopathy from a herniated disc and they did not recommend surgery. (Ex. 36-4).

Claimant's attorney filed a petition to reopen the claim. (Exs. 35, 37). The insurer recommended denying Own Motion relief, asserting that any issues involving the denial of claimant's current back condition were previously addressed by the August 17, 1993 DCS. (Ex. 40). Claimant requested a hearing. The Board postponed action on claimant's Own Motion request, pending ALJ Black's Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that there had been no change in claimant's low back condition and claimant's disk injury at L4-5 continued to present elements of L4 radiculopathy. Regarding the DCS, the ALJ reasoned that the factual contention in paragraph 12B of the DCS was not sustainable on this record. The ALJ concluded that the DCS disposed only of the aggravation claim, not the underlying claim. The ALJ set aside the insurer's *de facto* denial of claimant's current low back condition.

The insurer argues that the DCS precludes claimant's current low back condition claim. According to the insurer, the DCS settled claimant's pending aggravation claim *and* his current low back condition. In contrast, claimant contends that the DCS settled his then-current condition, which was an aggravation claim of the accepted injury. He argues that his current condition had not been diagnosed at the time of the DCS and, therefore, there is no claim preclusion.

Thus, although the parties agree that the DCS was intended to address claimant's aggravation claim, they dispute whether the DCS disposed of claimant's then-current low back condition. We interpret the terms of the DCS by applying standard rules of contract construction. *Taylor v. Cabax Saw Mill*, 142 Or App 121, 124 (1996); *Trevitts v. Hoffman-Marmolejo*, 138 Or App 455, 459 (1996). Generally, that review consists of two steps, beginning with a determination whether the terms of the agreement are ambiguous and, if so, proceeding to a determination of the "objectively reasonable construction of the terms" in the light of the parties' intentions and other extrinsic evidence. *Taylor*, 142 Or App at 125.

On October 8, 1991, the insurer issued a denial of claimant's back condition, asserting that the "condition is not related to your industrial claim with [the employer], but is most likely caused from your landscaping activities." (Ex. 10). The insurer denied compensability and responsibility of claimant's current need for treatment. (*Id.*) Claimant requested a hearing. An Opinion and Order issued on December 31, 1992, setting aside the insurer's denial. (Ex. 13).

The insurer appealed the December 31, 1992 Opinion and Order. While Board review was pending, the parties entered into a DCS on August 17, 1993. (Ex. 21). The DCS indicated that claimant had filed a claim for aggravation of the accepted condition and the insurer had issued a denial on October 8, 1991. (Ex. 21-1). Paragraphs 9 and 10 of the DCS provided that the insurer "herein issues its denial of claimant's current low back condition including radiculopathy at L4 secondary to far lateral disc" and claimant "herein" appealed the denial. (Ex. 21-2). The DCS provided, in part:

> "11. A bona fide dispute exists among the parties as to the compensability of claimant's claim for workers' compensation benefits related to his current low back condition and the parties have agreed to compromise and settle the denied and disputed claim according to the provisions of ORS 656.289(4);
>
> "12. The factual allegations and legal positions of the parties may be summarized as follows:
>
> "A. Claimant: Claimant contends that his compensable 1986 injury that occurred while he was employed at [the employer] is the major contributing cause of his current low back condition including L4 radiculopathy secondary to far lateral disc, therefore his claim and current condition remain compensable.

"B. Insurer: [The insurer] contends that claimant had a preexisting disease or condition when he sustained his 1986 compensable injury and that his preexisting disease or condition, together with his 1992 off-work activities are, in combination, the major contributing cause of his current low back condition including L4 radiculopathy secondary to his far lateral disc, therefore his current low back condition, including L4 radiculopathy secondary to his far lateral disc, is not compensable." (Ex. 21-2, -3; underline in original).

The DCS provided that claimant should receive $11,500 and the insurer's denial "as stated above in paragraph 10, including and incorporating the contentions set forth in paragraph 12B above, shall be affirmed." (Ex. 21-3). The DCS also provided that claimant's requests for hearing against the insurer, "including all raisable issues," shall be dismissed with prejudice. (Ex. 21-3, -4).

After reviewing the terms of the DCS, we agree with the insurer that the DCS disposed of claimant's pending aggravation claim *and* his then-current low back condition. Paragraph 6 of the DCS indicated that the insurer had issued a denial of claimant's aggravation claim on October 8, 1991. (Ex. 21-1). In paragraph 9 of the DCS, the insurer expressly issued a denial of "claimant's current low back condition including radiculopathy at L4 secondary to far lateral disc[.]" (Ex. 21-2). Claimant appealed that denial. (*Id.*) In paragraph 11, the parties agreed that they had a bona fide dispute "as to the compensability of claimant's claim for workers' compensation benefits related to his current low back condition" and the parties agreed to settle the denied and disputed claim. (*Id.*) Thus, the terms of the DCS expressly provided that the parties agreed to settle claimant's current low back condition claim. In paragraph 12B, the insurer set forth the basis for its position that claimant's current low back condition was not compensable. (Ex. 21-3). Both parties agreed that the insurer's denial, which included the denial as set forth in paragraph 12B, "shall be affirmed." (*Id.*)

We find no ambiguity in the terms of the August 17, 1993 DCS. By its plain and unambiguous terms, the DCS disposed of claimant's aggravation claim *and* his then-current low back condition claim. *Compare Emily Y. Logsdon-McBee*, 49 Van Natta 1335 (1997) (DCS had no preclusive effect on the carrier's current condition denial because that condition had not been denied at the time of the DCS). As further support for our conclusion, we note that the October 21, 1993 CDA stated that the parties had "entered into a *current condition disputed claim settlement*, by the terms of which claimant received $11,500 and agreed that his low back condition, including far lateral L4-5 disc, was no longer compensably related to his work activities and conditions at [the employer]." (Ex. 22-3; emphasis added).

We conclude that the August 17, 1993 DCS disposed of claimant's then-current low back condition. To the extent the medical evidence establishes that claimant's current low back condition is the same condition that was treated and diagnosed in connection with the DCS, he is precluded from relitigating his low back condition.

The DCS referred to claimant's condition as a "current low back condition including radiculopathy at L4 secondary to far lateral disc[.]" (Exs. 21-2, -3). On review, claimant asserts that the condition for which he is now seeking compensation was diagnosed as "acute denervation in the right tibialis anterior, vastus lateralis and paraspinals at L4-5 and L5-S1. Signs of chronic denervation or reinervation seen in the right tibialis anterior muscle." (Ex. 27-2). Claimant's description of his current condition is from a February 21, 1997 electromyography report from Dr. Edmonds. After reviewing the medical evidence, however, we do not agree with claimant's description of his current low back condition. Rather, we find that later medical reports after further testing indicated that claimant's current low back condition is still a right-sided far lateral L4-5 disk herniation with L4 radiculopathy. We reach that conclusion for the following reasons.

Claimant sought treatment on February 7, 1997 from Dr. Edmonds, neurologist. After examining claimant, Dr. Edmonds concluded that his "symptoms are similar to those which he reported in 1989 through 1993." (Ex. 25-3). Nevertheless, she recommended further testing. Nerve conduction studies by Dr. Edmonds on February 21, 1997 showed mild right posterior tibial neuropathy. (Ex. 27-1). Electromyography on the same date showed "[p]ossible right L5 radiculopathy." (Ex. 27-2). Dr. Edmonds reported that the MRI showed a scar or recurrent disc herniation on the right at L4-5 and she referred claimant to a neurosurgeon. (Ex. 28).

On March 17, 1997, claimant was examined by Dr. Gallo, neurosurgeon. (Ex. 29). Dr. Gallo reported that claimant had an 11-year history of right leg radicular pain that had become more painful over the last two months. (Ex. 29-1). She reported that claimant's recent MRI showed mild to moderate disc degenerative disease at L4-5 with a mild decrease in disc height, but she found no evidence of any recurrent disc herniation. (Ex. 29-4). She remarked that claimant had the "same pain he has always had, and the same distribution of numbness, only worse recently." (*Id.*) Dr. Gallo did not recommend surgery.

On May 14, 1997, claimant was examined by Dr. Hacker, neurosurgeon. (Ex. 31). He initially diagnosed failed laminectomy syndrome with chronic low back and right lower extremity pain. (Ex. 31-2). He recommended a lumbar myelogram with a CT follow-up, which were performed on May 28, 1997. (Exs. 32, 33). After reviewing the test results, Dr. Hacker recommended selective nerve root blocks, which were performed by Dr. Karasek. (Exs. 33B-2, 33C, 33D).

On October 3, 1997, Dr. Hacker reported that claimant's myelogram confirmed a far lateral component at L4-5 with compression of the exiting L4 nerve root. (Ex. 34). He recommended a "complete discectomy, thorough decompression, fusion and fixation with BAK via posterior approach at the L4-5 level[.]" (*Id.*) In a later report, Dr. Hacker said that the selective nerve root block confirmed the L4 nerve root as the source of claimant's low back pain. (Ex. 38-1). He concluded that the various tests, as well as claimant's neurological examination showed deficits consistent with an L4 radiculopathy and he continued to recommend surgery. (*Id.*)

We are persuaded by Dr. Hacker's diagnosis because it is well-reasoned and based on several tests. Dr. Hacker diagnosed claimant's current low back condition as a far lateral component at L4-5 with compression of the exiting L4 nerve root. (Ex. 34). The August 17, 1993 DCS referred to claimant's condition as a "current low back condition including radiculopathy at L4 secondary to far lateral dis[c]." (Exs. 21-2, -3). Based on the medical evidence, we are not persuaded by claimant's argument that his current low back condition was not diagnosed at the time of the DCS. Rather, we find that claimant's current low back condition is the same as the low back condition he had at the time of the DCS.

Our conclusion is supported by reports from Drs. Edmonds and Gallo, which indicated that claimant's now-current symptoms were similar to the symptoms he had been having since the 1986 injury. After examining claimant, Dr. Edmonds reported that his "symptoms are similar to those which he reported in 1989 through 1993." (Ex. 25-3). Dr. Gallo reported that claimant had the "same pain he has always had, and the same distribution of numbness, only worse recently." (Ex. 29-4).

In sum, we find that claimant's current low back condition is the same as the low back condition he had at the time of the DCS. As we discussed earlier, the August 17, 1993 DCS disposed of claimant's then-current low back condition. By the terms of the DCS, the parties agreed that claimant's then-current low back condition, including L4 radiculopathy secondary to his far lateral disc, was not compensable. (Ex. 21). Consequently, we conclude that claimant is precluded by the terms of the DCS from litigating the compensability of his current low back condition.

ORDER

The ALJ's order dated September 17, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
CHRISTINE M. WILSON, Claimant
WCB Case No. 98-05234
ORDER ON REVIEW
Kryger, 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) Marshall's order that awarded an assessed attorney fee of $3,000. On review, the issue is attorney fees.

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

After finding that claimant proved compensability of her low back injury, the ALJ decided that "claimant's counsel is entitled to an assessed attorney fee for prevailing over SAIF's denial. ORS 656.386(1)." The ALJ further stated that, "[i]n awarding the fee below, I have considered the factors set forth in OAR 438-015-0010(4)." The ALJ then ordered SAIF to pay $3,000 as an assessed attorney fee.

On review, SAIF contends that, under *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), the ALJ's order is insufficient with regard to the attorney fee award. Specifically, SAIF contends that the ALJ was required to make findings for each of the factors contained in OAR 438-015-0010(4)[1] and, because the order failed to do so, asks the Board to vacate and remand.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to merely describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See McCarthy*, 327 Or at 188; *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, SAIF did not (and continues not to) provide any discussion or argument concerning the application of the rule-based factors. Because the ALJ indicated that he had considered those factors in assessing the fee, we find the order, as well as the record, sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.

In addition to the ALJ's discussion, we note the following. The hearing lasted nearly one and one-half hours. The record consisted of 31 exhibits; claimant's attorney generated at least two medical opinion reports.

The compensability issue was of average complexity. The benefit secured for claimant also appears to be average. Because the medical reports concerning causation were divided, there was a risk claimant's attorney would go uncompensated. Both attorneys were experienced and skillful. Finally, there is no assertion of frivolous issues or defenses.

Based on these factors, especially the time devoted to the case , the complexity of the issue, and the value of the interest involved, we agree with the ALJ that $3,000 is a reasonable attorney fee. Finally, claimant's attorney is not entitled to an attorney fee for defending the attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

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

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[1] In determining a reasonable attorney fee, the rule requires the ALJ to consider the following factors: (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 an attorney's efforts may go uncompensated; and (8) The assertion of frivolous issues or defenses.

In the Matter of the Compensation of
WILLIAM G. BALLEW, Claimant
WCB Case No. 98-04964
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that assessed a $3,000 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 set aside SAIF's denial of claimant's left wrist injury claim. He assessed a $3,000 attorney fee, having "considered the factors set forth in OAR 438-015-0010(4)."

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.

Here, as in *Underwood*, claimant's attorney did not submit a statement of services or make a specific attorney fee request and 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 2332.

Finally, we provide the following additional reasoning. With regard to the time factor, we note that the hearing lasted one hour and claimant was the only witness who testified. The record was made up of 17 exhibits, including at least one medical report generated by claimant's attorney.

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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."

Compared with compensability disputes presented to this forum for resolution, we find that the compensability issue is of average complexity. The value of the interest involved and the benefit secured for claimant are also average. Because the medical reports concerning causation were divided, there was a risk claimant's attorney might go uncompensated. Finally, both attorneys were experienced and skillful.

Based on these factors, especially the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $3,000 is a reasonable attorney fee. 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 October 14, 1998 is affirmed.

In the Matter of the Compensation of
WILLIAM R. MELLOR, JR., Claimant
WCB Case No. 98-03929
ORDER ON RECONSIDERATION
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

The insurer requests reconsideration of our January 13, 1999 order that adopted and affirmed the Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's claim for a low back and right hip injury. Specifically, the insurer reiterates the arguments it made previously on review and contends that by adopting the ALJ's order, we did not address "important issues of the worker's credibility and its factual and legal consequences."

The insurer first notes that the ALJ found Levin, a witness to claimant's injury, generally more reliable than claimant. Levin was a yarder operator who was 30 or 40 feet from claimant when the accident occurred. The ALJ generally relied on Levin's testimony to conclude that an incident occurred and that claimant was hit by a branch. The ALJ, however, was not persuaded that Levin could be certain that claimant was hit only on the right calf. Based on the testimony of claimant's wife, the medical evidence and the fact that the limb that hit claimant had many branches, the ALJ found that there was persuasive evidence that claimant was also hit on the low back/right hip as well as the right calf. We agree with and have adopted the ALJ's finding.

The insurer next argues that claimant gave divergent histories of the injury to the medical experts and argues that medical evidence is necessary to establish compensability of claimant's low back/right hip injury. The insurer contests the ALJ's conclusion that expert medical evidence was unnecessary because claimant's injury was uncomplicated. The insurer argues that doubts regarding claimant's credibility render this case a complicated situation which requires expert medical evidence in order to establish compensability. *See Uris v. Compensation Department*, 247 Or 420 (1967) (when a causation issue presents a complex medical question, expert medical opinion is required to prove compensability); *see also Barnett v. SAIF*, 122 Or App 279 (1993).

We disagree. Although the insurer has raised doubts about claimant's version of how his injury occurred, other evidence established that claimant was hit by a limb in the low back/right hip. Thus, like the ALJ, we are not persuaded that this case presents a complicated situation. Moreover, we agree with and have adopted, the ALJ's reasoning and conclusion regarding the factors listed in *Uris*[1] for

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[1] The factors listed in *Uris* for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

determining whether a case is medically complex such that expert medical opinion is necessary to establish compensability. After applying these factors, the ALJ concluded that expert medical evidence regarding causation was unnecessary. Because the ALJ's order adequately addresses the application of the *Uris* factors, we find it unnecessary repeat that analysis here.

Finally, the insurer cites *Feliz Contreras*, 50 Van Natta 1685 (1998) and argues that our reasoning in *Contreras* should apply to the present case. *Contreras* presented different facts and thus is distinguishable. In *Contreras*, the claimant's symptoms did not appear immediately. In the present case, claimant's symptoms appeared immediately, and the injury was reported the same day it occurred. There is no evidence that claimant had any low back or right hip problems previously and no medical evidence establishes that the work injury could not have caused claimant's injury. Under such circumstances, we do not find *Contreras* helpful in deciding the present case.

Accordingly, our January 13, 1999 order is withdrawn. On reconsideration, as supplemented herein, we republish our January 13, 1999 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CURTISS N. SMITH, Claimant
WCB Case No. 98-05203
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the SAIF Corporation's denial of his left knee injury claim; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

In upholding SAIF's denial of claimant's left knee injury claim, the ALJ reasoned that claimant had a preexisting left knee condition (osteochondritis dissecans) that combined with a work injury on January 22, 1998 to cause disability and a need for medical treatment. The ALJ then found the medical opinions from the initial attending physician, Dr. Craven, and a physician, Dr. Thompson, who reviewed medical records at SAIF's request, established that the preexisting condition was the major contributing cause of the disability and need for treatment. Therefore, the ALJ concluded that claimant's left knee condition was not compensable under ORS 656.005(7)(a)(B).

On review, claimant contends that the ALJ failed to properly analyze the medical evidence with respect to ORS 656.005(7)(a)(B). In addition, noting that Dr. Craven diagnosed a left knee strain, claimant argues that he sustained a compensable injury at least to the extent that he suffered a left knee strain as a result of the incident in January 1998. Thus, claimant asserts that SAIF's denial should be set aside at least as to the knee strain condition. We disagree.

In *Charles L. Grantham*, 48 Van Natta 1094 (1996), the preponderance of the evidence established that the claimant's preexisting degenerative disc disease combined with a work- related lumbar strain at the outset, and that the preexisting disease was the major contributing cause of the combined condition. However, the claimant asserted that the "combined condition" analysis under *former* ORS 656.005(7)(a)(B) did not apply to the initial work-related lumbar strain, but applied only to his condition after the initial strain resolved. We found, however, that the court in *Tektronix, Inc. v. Nazari*, 117 Or App 409 (1992), *on recon* 120 Or App 590, *rev den* 318 Or 27 (1993), had rejected the "two-step" analysis proposed by the claimant. Specifically, in *Nazari*, the court explained that *former* ORS 656.005(7)(a)(B) was applicable in the context of an initial injury claim if, in the initial claim, the "the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition." 120 Or App at 594.

In *Grantham*, we determined that the *Nazari* analysis remained viable under *amended* ORS 656.005(7)(a)(B), which provides that if "an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability or need for treatment of the combined condition." Because the work injury combined with the claimant's preexisting degenerative disc disease at the outset, we concluded in *Grantham* that compensability of the claim was properly analyzed under amended ORS 656.005(7)(a)(B). *See also Julia A. Watson*, 48 Van Natta 1598 (1996).

Here, we find the medical evidence establishes that the January 1998 work injury combined with a preexisting left knee condition at the outset. (Exs. 20-2, 31-2). Accordingly, we conclude that the ALJ properly analyzed compensability of this claim under ORS 656.005(7)(a)(B). Moreover, we agree with the ALJ's reasoning that the preexisting left knee condition is the major contributing cause of claimant's need for treatment and disability. Thus, we also agree that the claim is not compensable under ORS 656.005(7)(a)(B).[1]

ORDER

The ALJ's order dated October 23, 1998 is affirmed.

[1] Claimant asserts that the ALJ should have interpreted Dr. Craven's opinion that the January 1998 incident was "a" major contributing cause of claimant's need for treatment as having satisfied *the* major contributing cause standard. (Ex. 29). We disagree. *See Michael A. Crause*, 49 Van Natta 1022, 1024 (1997). Moreover, Dr. Craven subsequently issued a report in which he concluded that the preexisting left knee condition was "the" major contributing cause of claimant's need for treatment and disability. (Ex. 31). Considering Dr. Craven's opinion as a whole, we find that it does not satisfy claimant's burden of proof.

In the Matter of the Compensation of
CAROL J. MULLINS, Claimant
WCB Case No. C8-02458
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On January 22, 1999, the Board received the parties' amended claim disposition agreement (CDA) in the above-captioned matter.[1] Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides for a total consideration of $12,400; $9,775 payable to claimant and $2,625 to her attorney. However, the body of the CDA, (page 3), provides for an attorney fee of $2,600, and (page 4) $9,800 payable to claimant. In interpreting the CDA, we rely on the more specific provisions in the body of the CDA regarding the attorney fee and amount payable to claimant, rather than the amounts listed in the more general provisions on the first page of the CDA. Accordingly, consistent with the specific provisions in the body of the agreement, we interpret the CDA as providing for a total consideration of $12,400; $9,800 payable to claimant and $2,600 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 $2,600, payable to claimant's counsel, is also approved.

[1] We had previously requested addendums correcting other problems with the original CDA. The parties have submitted an amended CDA which has corrected the problems identified in our prior addendum requests.

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.

February 3, 1999 Cite as 51 Van Natta 199 (1999)

In the Matter of the Compensation of
PATRICIA A. CHEATHEM, Claimant
WCB Case No. 98-03360
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
Mannix, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnson's order that found claimant's claim was prematurely closed and set aside an Order on Reconsideration on that basis. On review, the issues are premature closure and, if the claim was not prematurely closed, extent of unscheduled permanent disability.[1] We reverse.

FINDINGS OF FACT

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

Claimant, age 45 at the time of hearing, has a history of hypertension. Beginning in June 1992, when her blood pressure was measured as high as 210/120, she was prescribed anti-hypertension medication. She took the medication periodically over the next few years. (Exs. 3-10, 11, 12).

Meanwhile, in early 1992, claimant began working for the employer as a school custodian. On November 28, 1994, while working with another custodian to dismantle a volleyball net in the school gymnasium, claimant was struck in the head by one of the metal poles supporting the net. Her co-worker had dropped the pole, which hit claimant on the left side of her head above the ear. Claimant did not lose consciousness, but was momentarily dazed and disoriented. She then experienced a severe headache.

Claimant sought treatment the next day and was diagnosed with a head contusion, muscle contraction headaches and extremely elevated blood pressure. An x-ray of the skull was normal. (Ex. 20). Dr. Hall gave claimant a prescription for Procardia for her hypertension and advised that she return to her regular physician to get her blood pressure under control. (Ex. 19)

Claimant returned for emergency treatment on December 1, 1994 complaining of headache. She advised the emergency room physicians she had experienced headaches on and off for the last three years, but she had markedly worse head pain since being struck by the pole three days prior. Dr. Rucker diagnosed headache secondary to hypertensive encephalopathy. She was admitted to the hospital for two days to monitor her blood pressure. A CT scan of claimant's head showed no evidence of intercranial hemorrhage, but likely small lacunar infarction. (Exs. 21-41).

Claimant continued to experience head and neck pain. On December 12, 1994, she began treating with Dr. Michels, a chiropractor, who diagnosed acute cervical and thoracic strains, occipital headaches and post-concussion syndrome. (Ex. 44). Dr. Michels also referred claimant to Dr. Holden, an ear, nose and throat specialist, who diagnosed a probable vestibular dysfunction secondary to her on-the-job injury. (Ex. 49).

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[1] The employer moves to strike claimant's respondent's brief, asserting that the brief was untimely filed. We decline to address the employer's motion because, even if we considered claimant's brief, our decision on the merits would be unchanged.

Following further testing at the Clinical Vestibular Lab, Dr. Holden diagnosed a non-specific vestibular dysfunction problem. He recommended six weeks of bedrest to see whether the problem would resolve. He also referred claimant to Dr. Black, who diagnosed bilateral inner ear concussion syndrome related to the work injury. The six weeks of bedrest did not result in any improvement in her symptoms. Drs. Black and Holden suggested possible surgical exploration and closure of the fistula. (Exs. 49, 55-58, 61-63).

On May 3, 1995, claimant was examined by Drs. Watson and Stanford at the employer's request. Because neither physician was qualified to perform a neuro-otologic examination, the doctors limited their examination to claimant's physical complaints (*i.e.* neck pain). (Ex. 64).

In mid-May, claimant was seen by Dr. Turco for a psychiatric examination. He found no specific psychiatric disturbance but questioned whether claimant had organic deficits associated with encephalopathy, possibly hypertensive and possibly traumatic. (Ex. 67).

On May 31, 1995 claimant was examined by Dr. Schleuning, a head and neck surgeon. He diagnosed a probable middle ear concussion or abnormality from the injury. He recommended a vigorous, active physical therapy regimen, and did not believe that any surgery was indicated. (Ex. 68). In an August 1995 supplemental report, Dr. Schleuning clarified that, although claimant experienced dizziness and unsteadiness due to her work accident, he did not find evidence of any perilymphatic fistula or endolymphatic hydrops. He opined that claimant's symptoms would resolve over time, so long as she underwent active physical therapy. (Ex. 71).

The employer accepted claimant's claim for disabling head contusion, cervical sprain/strain and thoracic sprain/strain. Thereafter, in August 1995 (after further clarification from Dr. Holden) the employer also accepted a disabling vestibular dysfunction secondary to post-traumatic inner ear concussion. (Exs. 72-75).

Claimant continued to experience symptoms of headache, vertigo, neck pain, hypertension and depression for the next few years. Between January 1996 and April 1997, claimant saw Dr. Cunningham approximately once a month for her depression and hypertension. During this time, claimant also treated with Dr. Michels for her neck pain and saw Dr. Holden for her vestibular dysfunction.

Meanwhile, in February 1997, claimant was examined by a panel of specialists (Drs. Schleuning, Zimmerman, Holden and Turco) at the employer's request. The panel concluded that claimant's lacunar infarction was clinically significant, but most likely caused by her uncontrolled hypertension. They also opined that claimant was able to return to work with restrictions, including no overhead work and no standing on ladders or stools. The panel further opined that the restrictions may be permanent. (Exs. 123-125).

On September 9, 1997, Dr. Holden opined that claimant was medically stationary. He reported that claimant's major complaints were neck, shoulder and back pain with some headaches, although he found no clinical evidence of such pain. (Ex. 135). On September 15, 1997, Dr. Cunningham reported that she had terminated claimant's care as of May 1997, when claimant failed to appear for her scheduled appointments. (Ex. 137).

On September 19, 1997, claimant began treating with Dr. Neuberg because the employer had required her to obtain medical services through an MCO. Dr. Neuberg found that claimant had normal blood pressure and nearly normal range of motion of the neck. She continued claimant's work restriction, but reported that claimant's current subjective complaints were unrelated to her November 1994 work injury. (Ex. 139).

On October 21, 1997, Dr. Turco reported that he concurred with Dr. Holden's determination that claimant was medically stationary as of September 9, 1997. Dr. Turco also agreed with Dr. Neuberg's assessment of claimant. He concluded that claimant had no permanent impairment related to her 1994 work injury. (Ex. 141). Similarly, on October 30, 1997, Dr. Schleuning reported that he concurred with the findings and determinations of Drs. Holden and Neuberg. He also concluded that claimant had no physical permanent impairment attributable to her work injury. (Ex. 142).

The employer issued a Notice of Closure on November 20, 1997, awarding claimant temporary disability through August 28, 1997 but no permanent disability. (Ex. 143). Claimant requested reconsideration, and was scheduled for a medical arbiter examination.

Meanwhile, claimant was reexamined by Dr. Neuberg on December 11, 1997. Dr. Neuberg found normal range of motion of claimant's neck and shoulder. She diagnosed chronic myofascial pain without objective findings. Dr. Neuberg also concluded that claimant needed no further treatment related to her 1994 injury and that there was no objective basis for claimant's work restrictions. (Ex. 151). The next day, Dr. Neuberg concurred with the opinions of Drs. Holden, Turco and Schleuning that claimant was medically stationary without permanent impairment related to her industrial injury. (Exs. 153, 155).

In a January 29, 1998 report, Dr. Holden opined that claimant became medically stationary in August 1997, but that she had not returned to "normalcy as she was prior to the injury" of November 1994. Dr. Holden reported that a closing examination to rate claimant's injury-related permanent impairment would be appropriate. (Ex. 159).

On February 12, 1998, Dr. Neuberg opined that claimant could possibly be helped with further evaluation of her inner ear injury. She suggested that claimant return to Dr. Schleuning for reevaluation. (Ex. 161).

Claimant was seen by Dr. Hodgson, an ear, nose and throat specialist, for a medical arbiter examination on March 17, 1997. Dr. Hodgson diagnosed inner ear concussion syndrome, subsided, cervical vertigo and normal hearing. He found no objective abnormalities on his vestibular evaluation. Dr. Hodgson concluded that claimant was medically stable and able to perform her regular work activities. He also suggested that claimant's ongoing dizziness was a side effect and interaction of the various drugs claimant was taking, including Zoloft, Vasotec, hydrocodone, Trazodone and Adalat. (Ex. 163).

Claimant was also examined by Dr. Peterson, a neurologist, at the request of the Appellate Review Unit. Dr. Peterson diagnosed post-traumatic headache syndrome complicated by rebound headache due to daily use of oxycodone, depression, insomnia, mild cognitive difficulties likely related to post-concussive syndrome, lacunar infarcts likely related to ongoing hypertension and complaints of low back pain. Dr. Peterson reported that the cause of claimant's condition is a "complicated matter," because of her preexisting hypertension and depression, but concluded that her overall cerebral condition involved a combination of the effects of uncontrolled hypertension and the effects of post-concussive syndrome. Dr. Peterson also identified loss of cervical and thoracic range of motion and a limited ability to repetitively use the cervical spine due to post-traumatic headache syndrome, as well as impaired olfaction. She noted that because claimant has had no neuropsychological testing, she could not state with any certainty whether claimant had neuro-cognative impairment and, if so, whether it was related to post-concussive syndrome. Dr. Peterson found evidence of an episodic neurological disorder (headaches) and a sleep disorder, and placed claimant in a Class II level of head brain injury impairment.

Pursuant to an April 14, 1998 Order on Reconsideration, claimant was awarded 21 percent unscheduled permanent disability. The employer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Based on Dr. Neuberg's February 12, 1998 correspondence and the fact that claimant had not been evaluated by a neuropsychologist with expertise in head injuries, the ALJ concluded that claimant's claim had been prematurely closed. On review, the employer argues that claimant was medically stationary as of August 1997, and therefore her claim was not closed prematurely. We agree.

A claim may not be closed unless claimant's condition is medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 20, 1997 Notice of Closure, considering claimant's condition at the time of closure and not subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981). Although medical evidence submitted after closure can be considered in determining whether the claim was prematurely closed, the evidence must relate to claimant's condition at the time of closure. *See Scheuning v. J. R. Simplot & Co.*, 84 Or App at 622 (1987).

In this case, claimant's compensable injury involves four accepted conditions, a head contusion, cervical sprain/strain, thoracic sprain/strain and a vestibular dysfunction secondary to post-traumatic inner ear concussion. Dr. Holden, who treated claimant's vestibular dysfunction between December 1994 and August 1997, opined on September 9, 1997 that claimant was medically stationary. He reported that claimant's condition had leveled off, and he did not anticipate any significant improvement through additional treatment or the passage of time. Drs. Schleuning and Turco agreed with this assessment.

Similarly, Dr. Neuberg, who became claimant's attending physician in the fall of 1997, opined that claimant's current subjective complaints (of chronic headaches, myofascial pain and depression) were unrelated to her November 1994 work injury. She agreed with Drs. Holden, Schleuning and Turco that claimant was medically stationary.[2]

Although Dr. Neuberg subsequently reported (in February 1998) that claimant's inner ear injury could possibly be helped by further evaluation by Dr. Schleuning, this is not persuasive evidence that claimant was not medically stationary at claim closure. Indeed, Dr. Neuberg did not express any expectation that a reevaluation would materially improve claimant's condition. Further, as noted above, both Dr. Schleuning and Dr. Holden had previously opined that claimant's condition (including her inner ear dysfunction) was medically stationary by August 1997.

Moreover, considering the opinions of claimant's attending physicians, Dr. Peterson's arbiter's report also does not persuade us that claimant's claim was prematurely closed. Although Dr. Peterson suggested that claimant be evaluated by a neuropsychologist with expertise in head injury, and reported that claimant's ongoing headache condition was related to her compensable condition and not yet medically stationary, we find that her opinion is based on an incomplete or inaccurate history. As set forth in her report, Dr. Peterson believed that claimant had no history of headaches prior to the work injury, but this understanding is belied by claimant's treatment records between 1992 and 1994. Claimant complained of headaches or head pressure related to her uncontrolled hypertension on a number of occasions during this time.[3] (*See, e.g.*, Exs. 6, 8, 9, 26). Consequently, on this record, we find that claimant has not established that she was not medically stationary at the time of claim closure.

Having determined that claimant's claim was not prematurely closed, we turn to an evaluation of the extent of claimant's injury-related permanent impairment. The employer argues, based on the opinions of Drs. Holden, Neuberg, Turco and Schleuning, that claimant has not established any permanent impairment due to her compensable injury.[4]

The Order on Reconsideration awarded claimant 21 percent unscheduled permanent disability based upon Dr. Peterson's arbiter's report. Specifically, claimant was awarded 12 percent for lost range of motion and 9 percent for social, vocational and adaptability factors.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, only the opinions of the attending physician and the medical arbiter, if any, may be considered. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). Where a medical arbiter is used, as in this case, we do not automatically rely on the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment due to the injury. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994); *Carlos S. Cobian*, 45 Van Natta 1582 (1993).

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[2] Although claimant did not undergo a formal closing examination prior to claim closure, a closing examination report is not a condition precedent to issuance of a closure notice. Thus, the absence of a specific closing examination by Dr. Holden, Dr. Neuberg or a neuropsychologist with expertise in head injury is not grounds for setting aside the Notice of Closure as premature. *See, e.g., Nancy L. Sabin*, 50 Van Natta 508 (1998); *Estella M. Rogan*, 50 Van Natta 205 (1998).

[3] Indeed, on December 1, 1994, claimant advised the emergency room physician that she had headaches *on and off for the last three years*, but it was markedly worse after being struck in the head a few days ago. (Ex. 26-1).

[4] All four of these physicians agreed that claimant had no impairment attributable to her November 1994 injury, although Dr. Holden later opined that claimant had not returned to "normalcy as she was prior to the injury." Dr. Neuberg reported in September 1997 that claimant had "nearly normal" range of motion of the neck, and found normal neck and shoulder range of motion on December 11, 1997.

Here, after considering the findings and opinions of claimant's attending physician[5] and those of the medical arbiters, we find that arbiter Dr. Peterson provided the most thorough and complete evaluation of claimant's loss of cervical and thoracic motion as of the date of the Order on Reconsideration.[6] Indeed, Dr. Peterson measured claimant's range of motion with the dual inclinometric technique and determined the best true measurements. Dr. Neuberg, on the other hand, did not document the technique she used to measure range of motion when she evaluated claimant in September and December 1997. Consequently, like the Appellate Review Unit, we find that claimant has established an impairment value of 12 percent, based on Dr. Peterson's range of motion findings.

In addition, we adopt the Appellate Review Unit's determination that claimant is entitled to a value of 1 for her age, a value of 0 for education, a value of 2 for skills (1+0+2= 3), multiplied by an adaptability value of 3 for a total social-vocational factor of nine. We therefore reinstate and affirm the Order on Reconsideration's award of 21 percent (67.20 degrees) unscheduled permanent disability.[7]

Because claimant's award of compensation was not ultimately disallowed or reduced by the employer's hearing request challenging the Order on Reconsideration's permanent disability award, claimant's attorney is entitled to an assessed fee for services at hearing. ORS 656.382(2); *See also Patricia L. McVay*, 48 Van Natta 317 (1996). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing 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, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated August 25, 1998 is reversed. The April 14, 1998 Order on Reconsideration is reinstated and affirmed. Claimant's counsel is awarded an assessed fee of $1,500 for services at hearing, payable by the employer.

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[5] An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Whether a physician qualifies as an "attending physician" is a question of fact. *See Debbie I. Jensen*, 48 Van Natta 1235, 1236 (1996). Here, although claimant treated with several physicians (including Dr. Holden) for her various accepted conditions, we find that Dr. Neuberg was claimant's "attending physician" at the time of claim closure. *See* ORS 656.245(2)(b)(B). Moreover, Dr. Neuberg was the only treating physician who made specific findings relating to claimant's cervical and/or thoracic range of motion at the time of claim closure.

[6] We agree with the determination of the Appellate Review Unit that a preponderance of the evidence (including the medical arbiter's reports) fails to establish that claimant is entitled to an impairment rating for diminished sense of smell, headache or a head/brain injury.

[7] Claimant's 12 percent impairment plus the value of 9 for social-vocational totals 21 percent.

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

Claimant requests reconsideration of our October 15, 1998 Own Motion Order, that declined to reopen his claim for the payment of temporary disability benefits. We concluded that the record did not establish that his compensable condition has worsened requiring surgery or hospitalization.

On October 27, 1998, we abated our October 15, 1998 order, and allowed the insurer 14 days in which to file a response to the motion. Having received the insurer's response and claimant's submissions, we proceed with our review. In doing so, we replace our prior decisions with this 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.*

In our prior order, we concluded that the epidural injections claimant underwent did not qualify as "surgeries" within the meaning of ORS 656.278(1)(a). *Victor Schunk*, 50 Van Natta 2049 (1998). There was no further evidence in the record at that time to suggest that surgery had been recommended or undertaken.

Following our order, Dr. Keene, one of claimant's consultant physicians, recommended that claimant undergo an anterior L5-S1 discectomy. Claimant relied on Dr. Keene's report in requesting reconsideration of our October 15, 1998 order.

On December 14, 1998, Dr. Berselli, an insurer-arranged medical examiner, agreed that claimant required surgery. He recommended a decompressive laminectomy at the L5-S1 level with disc excision. Based on Drs. Keene's and Berselli's opinions, the insurer has now submitted an amended own motion recommendation requesting that the claim be reopened for the provision of temporary disability compensation.

Claimant underwent an L5-S1 anterior discectomy on January 13, 1999. Thus, on this record, 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 January 13, 1999, the date he was 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
RONALD E. THOMAS, Claimant
Own Motion No. 97-0597M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's August 13, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from September 8, 1997 through May 14, 1998. The insurer declared claimant medically stationary as of May 14, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

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. 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 August 13, 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 a July 28, 1998 letter submitted by Dr. Hoff, claimant's treating physician, who had last examined claimant on May 14, 1998. Dr. Hoff opined that claimant was medically stationary and gave him a full release "effective as of the time of his last appointment, that being May 14, 1998."

Subsequent to the August 13, 1998 claim closure, Dr. Hoff examined claimant on September 17 and 24, 1998. Reporting that x-rays and a bone scan demonstrated an incomplete ingrowth present on the femoral prosthesis, Dr. Hoff recommended that claimant stay off his hip, "even if it means not working."

On December 17, 1998, Dr. Hoff withdrew his prior opinion regarding claimant's medically stationary status. Dr. Hoff provided the following explanation:

> "Unfortunately, I participated in this confusion in returning a stationary release for this patient in July of 1998. However, shortly, thereafter, follow up examination still showed that [claimant] had a very significant limp, and x-rays obtained in September of 1998 revealed the presence of incomplete ingrowth of the femoral component on this revised hip. *** x-rays shows that there is improvement from those signs seen in September of this year with the use of the Fosamax."

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. Hoff retracted his earlier opinion that claimant was medically stationary in July 1998 (which was rendered without an examination since May 1998) and opined that claimant's condition had materially improved since the May 1998 examination. Because of the x-ray and bone scan findings revealed as part of his September 1998 examinations, Dr. Hoff concluded that claimant's condition had not been medically stationary in July 1998. Specifically, based on the incomplete ingrowth of the femoral component of claimant's revised hip, Dr. Hoff determined that claimant's condition was not stable in July of 1998 and was getting progressively worse.

Dr. Hoff's December 1998 report is sufficiently explained to overcome his initial July 1998 opinion. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive). Dr. Hoff's subsequent opinion was based on medical examinations conducted, only four weeks after the insurer closed the claim. Inasmuch as the record does not suggest that claimant's condition changed between the August 13, 1998 claim closure and Dr. Hoff's September 17 and 24, 1998 examinations, we conclude that Dr. Hoff's subsequent opinion addresses claimant's condition at claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App at 622.

Based on Dr. Hoff's unrebutted opinion, we conclude that claimant was not medically stationary on August 13, 1998 when his claim was closed by the insurer. Therefore, we set aside the insurer's August 13, 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.

February 3, 1999 Cite as 51 Van Natta 206 (1999)

In the Matter of the Compensation of
VIRGIE WEBB, Claimant
Own Motion No. 97-0204M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Scott M. McNutt, Sr., Claimant Attorney
Brian L. Pocock, Defense Attorney

Claimant requests review of the self-insured employer's November 10, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from January 3, 1996 through September 15, 1998. The employer declared claimant medically stationary as of September 15, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

In an November 21, 1998 letter, we requested that the employer submit copies of materials it 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.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he/she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 10, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In July 1998, Dr. Kitchel, claimant's treating surgeon, referred claimant to a physical capacities examiner (PCE) for a closing examination. Based on the PCE's findings, Dr. Kitchel concurred that claimant was medically stationary as of September 15, 1998.

Dr. Kitchel also referred claimant to Dr. Kosek for an opinion regarding the possibility of implanting a spinal stimulator to help control claimant's chronic pain. Dr. Kosek examined claimant on September 10, 1998. Reporting that claimant had a stable spine with persistent pain, Dr. Kosek suggested that she may be a candidate for a spinal cord stimulator. Although Dr. Kosek recommended implanting a spinal cord stimulator, claimant has apparently not pursued the surgical procedure.

Under such circumstances, we are persuaded by Dr. Kitchel's opinion that claimant was medically stationary on September 15, 1998. In reaching this conclusion, we note that, in the absence of medical evidence proving a reasonable expectation that medical treatment or the passage of time would result in material improvement of claimant's condition, the need for continuing medical care for claimant's pain complaints does not establish that her condition is not medically stationary. *See Maarefi v. SAIF*, 69 Or App 527, 531 (1984); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Based on the foregoing reasoning, we find that claimant has not met her burden of proving that she was not medically stationary on the date her claim was closed.[1] Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's November 10, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

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

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 97-0181M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's August 26, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from May 7, 1997 through August 4, 1998. The insurer declared claimant medically stationary as of August 4, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 26, 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 October 20, 1998 letter, we requested that the parties submit copies of materials considered in closing the claim. Having received the parties' submissions, we will proceed with our review.

Claimant was examined by Dr. Frank, one of his treating physicians, in April and June 1998. On both occasions, Dr. Frank reported that claimant's neurological examination demonstrated no weakness or numbness in the lower extremities. Offering no further recommendations, he did not comment on claimant's medically stationary status.

Dr. Pearson, another of claimant's treating physicians, last examined claimant in May 1998. He submitted a medical report (Form 828) concluding that claimant was not medically stationary at that time.

On August 4, 1998, claimant was examined by Dr. Rosenbaum, who conducted an insurer-arranged medical examine (IME) and opined that "[t]his [claimant's] condition is medically stationary, he has reached maximum improvement from his injury and his claim could be closed now. There is no further recommended treatment." Relying on Dr. Rosenbaum's conclusion, the insurer declared claimant medically stationary as of August 4, 1998 and closed his claim on August 26, 1998.

Claimant argues that there are no documents in the record from his long-time treating physicians (Drs. Frank and Pearson) that would indicate that he was medically stationary at the time his claim was

closed. Claimant's apparent reliance that it must be an attending physician who can determine when a claimant is medically stationary is misplaced. It is well settled that for purposes of determining whether a claimant is medically stationary at the time of closure, we rely upon all competent medical evidence and not just the opinion of the attending physician. *See Patricia M. Knupp*, 46 Van Natta 2406 (1994); *Francisco Villagrana*, 45 Van Natta 1504 (1993); *Timothy H. Krushwitz*, 45 Van Natta 158 (1993).

After conducting a detailed review of claimant's medical history and performing an in-person examination, Dr. Rosenbaum, the IME doctor, provided a thorough analysis of claimant's current condition. He opined that, although claimant still had some ongoing back and leg discomfort, his condition was stationary and there was no additional treatment indicated.

On the other hand, Dr. Frank, claimant's attending surgeon, last saw claimant on June 15, 1998 (some two months prior to Dr. Rosenbaum's exam). At that time, Dr. Frank stated that claimant was to follow up with his primary care physician for an evaluation of his GI system. He also noted that claimant had no new neurologic changes such as weakness or numbness in the lower extremities and no problems with his gait. He did not schedule a follow up appointment.

We find Dr. Rosenbaum's opinion more persuasive than Dr. Frank's. In reaching this conclusion, we note that Dr. Frank's opinion does not address claimant's medically stationary status at the time his claim was closed. Moreover, Dr. Rosenbaum's opinion is based on a more thorough examination, which specifically addresses claimant's medical stationary status.

Dr. Pearson, claimant's primary care physician, last saw claimant on May 1, 1998. Although he did state that claimant was not stationary at that time, that opinion does not reflect claimant's medically stationary status when his claim was closed four months later. In addition, Dr. Pearson did not explain his reasoning for determining that claimant was not medically stationary.

In contrast to Dr. Pearson, Dr. Rosenbaum performed a thorough examination of claimant and a complete records review. His opinion is well-reasoned and based on objective findings. Thus, we find Dr. Rosenbaum's opinion regarding claimant's medically stationary status at the time of closure more persuasive than Dr. Pearson's unexplained opinion.

Claimant has also submitted a November 10, 1998 medical report from Dr. Karasek, consulting physician. Dr. Karasek recommended that claimant undergo a discography in order to determine the source of his chronic pain and decide whether further treatment was necessary.

In determining whether the claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622 (1987). Dr. Karasek did not examine claimant until three months after his claim was closed and does not address claimant's condition at the time of claim closure. As noted above, Dr. Rosenbaum's opinion was rendered at the time claimant's claim was closed and is based on his thorough examination of claimant and his review of claimant's medical history (which included Dr. Frank's and Dr. Pearson's treatment). Thus, we find Dr. Rosenbaum's opinion more persuasive than Dr. Karasek's opinion regarding claimant's medically stationary status when his claim was closed.

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

Accordingly, we affirm the insurer's August 26, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD K. McCULLOCH, Claimant
Own Motion No. 98-0520M
OWN MOTION ORDER
Juli Point, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable left knee strain/sprain injury. Claimant's aggravation rights expired on February 17, 1993. SAIF agrees that claimant's current high tibial osteotomy - left knee is causally related to his accepted condition for which it is responsible. However, SAIF opposes reopening of claimant's claim for the payment of temporary disability compensation, contending that claimant was not in the work force at the time of the current worsening.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). 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).

Here, claimant must prove that he was in the work force on October 26, 1998, the date he was hospitalized for surgery. SAIF contends that claimant was not in the force at the time of his current disability because he failed to provide proof that he remained in the work force. In response, claimant reports that he worked until a couple of months prior to his surgery and then was on unemployment until October 1998 when he began receiving Social Security benefits. In support of his representations, claimant submitted copies of his August 25, 1998 paystub, a January 11, 1999 affidavit attesting to his work history and work search, copies of his Social Security benefits forms and a listing of his job search for the period between May 1998 and September 1998.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to October 26, 1998, 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, claimant attested in his unrebutted sworn statement that he received unemployment benefits in September and October 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). 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 October 26, 1998, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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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).

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.

February 4, 1999 Cite as 51 Van Natta 210 (1999)

In the Matter of the Compensation of
JAMES E. HAMM, Claimant
Own Motion No. 99-0026M
OWN MOTION ORDER
Industrial Indemnity, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable condition. Claimant's aggravation rights expired on January 14, 1979. The insurer agrees that claimant's current "bone-on-bone degenerative changes of the medial compartment with significant varus alignment" is causally related to his accepted condition for which it is responsible. Although the insurer recommends reopening of the claim for the provision of temporary disability compensation, it contends that claimant was not in the work force at the time of the current worsening.

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

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

The insurer contends that claimant was not in the workforce at the time of the current disability because it has not received written evidence of current employment. However, with its recommendation form, the insurer submitted a chart note from Dr. Lantz, claimant's treating physician, reporting that claimant was in the workforce at the time of the current disability. In the November 3, 1998 chart note, Dr. Lantz stated: "[Claimant] continues to work as a foreman for [a city]. *** I have recommended high tibial osteotomy. think this would allow [claimant] to function better and probably continue with his current occupation, although that is uncertain." Additionally, claimant has submitted a copy of his 1998 W-2 form.

Based on these submissions, we conclude that claimant was in the workforce at the time of his current worsening. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINO VILLA-ACOSTA, Claimant
WCB Case No. 98-00789
ORDER ON REVIEW
Max Rae, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) declined to award claimant interim compensation in the form of temporary partial disability (TPD) payable at his temporary total disability (TTD) rate; and (2) declined to assess penalties for the SAIF Corporation's allegedly unreasonable failure to pay interim compensation. On review, the issues are entitlement to interim compensation, rate of interim compensation, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, supplementation, and summary. Claimant first sought medical treatment with Dr. Stringham, attending physician, on December 19, 1997, not December 12, 1997. (Exs. 1, 2-1).

Claimant is a citizen of Mexico. At hearing, the parties stipulated that, solely for the purposes of this matter, claimant's presence in the United States may be considered in violation of federal immigration laws, although claimant does not admit to such status. The parties also stipulated that the employer first knew of the claim on January 7, 1998. (Tr. 20-21).

In November 1987, claimant began working in the employer's nursery, which involved heavy physical labor. Claimant's last day of work with the employer was September 29, 1997, at which time he was earning $7.35 per hour. (Ex. 5). On that date, the employer learned that claimant's social security number was probably not correct. Claimant was laid off due to his inability to prove that he could legally work in the United States. (Exs. 2-1, 4, 9-1, 11-1).

From October 20, 1997 through December 2, 1997, claimant worked for another employer at a lumber mill. Claimant was laid off from that job due to lack of work. (Exs. 4, 6, 9-1, 11-1).

On December 19, 1997, claimant first sought medical treatment and reported the insidious onset of increasing low back pain over the last 12 months, with no initial precipitating event, but increased pain over the last three months. (Ex. 2-1). Dr. Stringham released claimant to modified work for two weeks. (Ex. 2-2). On January 2, 1998, Dr. Stringham examined claimant and decided not to continue the light work release, finding that he could not justify any work restriction. (Ex. 4-2).

On January 7, 1998, the employer first learned of claimant's claim. (Ex. 5). On January 12, 1998, Dr. Stringham placed claimant on modified work status through January 26, 1998. (Exs. 6, 8-3). As of February 26, 1998, the date of the hearing, SAIF had not accepted or denied the claim and was still within the 90-day period within which to timely accept or deny the claim.

On January 26, 1998, claimant was seen by Dr. Miller, M.D., who worked in the same clinic as Dr. Stringham. Dr. Miller released claimant to light duty. (Ex. 9). On February 2, 1998, Dr. Stringham examined claimant and released him to regular work. (Ex. 11-1).

The employer has a written modified work policy. (Ex. 14). The employer had modified work available within the restrictions set by Drs. Stringham and Miller. This work would have paid claimant's regular hourly wage of $7.35, and would have been for hours and days similar to claimant's regular work. On February 25, 1998, Dr. Stringham agreed that claimant would have been physically capable of performing the modified work as of December 19, 1997. (Ex. 16).

The employer did not offer the modified work to claimant because the employer understood that claimant was in the United States in violation of federal immigration laws and that if it offered claimant work while he was in that violation status, the employer would also be in violation of federal law. (Tr. 35-40).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that, given claimant's "illegal alien" status, ORS 656.325(5)(c)[1] was applicable and precluded claimant from receiving any temporary disability compensation. Specifically, the ALJ found that claimant's TPD rate was zero because the employer would have offered claimant modified work paying his regular wage but for claimant's "illegal alien" status, which would have made such a job offer illegal. The ALJ also rejected claimant's contention that OAR 436-060-0030(7)[2] is invalid.

On review, claimant renews his argument that he is entitled to TPD payable at his TTD rate whether or not ORS 656.325(5)(c) applies to his case. In addition, claimant renews his argument that OAR 436-060-0030(7) is invalid.

At hearing, SAIF had not accepted or denied the claim and was still within the 90-day period within which to timely accept or deny the claim. Therefore, the issue is entitlement to "interim compensation," which "refers to temporary disability payments which ORS 656.262 requires be made to a claimant who is off work as a result of an injury for the time between the employer's notice of the injury and acceptance or denial of the claim." *Nix v. SAIF*, 80 Or App 656, 658 n.1 (1986) (citing *Jones v. Emanuel Hospital*, 280 Or 147 (1977)). ORS 656.262(4)(a) provides, in relevant part, that "[t]he first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." Furthermore, ORS 656.262(4)(f) provides, in relevant part, that "[t]emporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician." It is claimant's burden to prove his entitlement to temporary disability benefits. ORS 656.266

In addition, ORS 656.325(5)(c) provides additional limitations regarding entitlement to temporary disability if a claimant is in the United States in violation of federal immigration laws. Per the parties' stipulation, for the purposes of this matter, claimant's presence in the United States may be considered in violation of federal immigration laws. Nevertheless, under the facts of this case, we conclude that ORS 656.325(5)(c) is inapplicable.

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

"(5) Notwithstanding ORS 656.268:

"* * * * *

"* * * * *

"(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 [temporary total disability] and commence payments pursuant to ORS 656.212 [temporary partial disability] when the attending physician approves employment in a modified job whether or not such a job is available." [Bracketed information added].

[2] OAR 436-060-0030(7) provides:

"Pursuant to ORS 656.325(5)(c), 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 whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

"(a) 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);

"(b) The attending physician has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

"(c) The attending physician agrees the employment appears to be within the worker's capabilities."

ORS 656.325(5)(c) explicitly requires that a carrier "cease payments pursuant to ORS 656.210 [TTD] and commence payments pursuant to ORS 656.212 [TPD] when the attending physician approves employment in a modified job whether or not such a job is available." But claimant was never entitled to receive TTD benefits following the employer's notice of the claim on January 7, 1998. In this regard, we adopt the ALJ's reasoning and conclusions that, following the employer's notice of the claim on January 7, 1998, Dr. Stringham, claimant's attending physician, only authorized modified work from January 12, 1998 through January 26, 1998.[3] *See Shanon M. Oliver*, 48 Van Natta 386 (1996) (interim compensation must be authorized by an attending physician under ORS 656.262(4)); *Nenita Stockie*, 48 Van Natta 299 (1996) (the responsibility to authorize temporary disability compensation cannot be delegated). Because claimant's attending physician did not release him from all work, he is not entitled to TTD. Thus, by its terms, ORS 656.325(5)(c) does not apply. Despite this conclusion, we nonetheless find that claimant was not entitled to temporary disability benefits after he was laid off from employment.

Temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296 (1985); *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75 (1991). Since "the policy behind interim compensation is to compensate an injured worker for having to leave work[,]" it need not be paid when a worker fails to demonstrate absence from work due to the compensable injury. *Weyerhaeuser Co. v. Bergstrom*, 77 Or App 425, 427 (1986). 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).

In determining whether claimant is entitled to temporary disability, we find *George B. Orazio*, 49 Van Natta 1982 (1997), instructive. In *Orazio*, the claimant sustained a compensable injury and was earning his at-injury wage while performing modified work when he was discharged for disciplinary reasons. We determined that ORS 656.325(5)(b)[4] did not apply because the claimant was not entitled to receive TTD at the time of termination.[5] Nevertheless, we found that the claimant was not entitled to temporary disability benefits after he was discharged from employment. In making that finding, we reasoned that temporary disability benefits were intended to replace wages lost due to a compensable injury. The claimant did not leave work due to an inability to work as a result of his compensable injury. Instead, he left work because he was discharged for disciplinary reasons. Therefore, we concluded that the claimant was not entitled to temporary disability benefits after the date he was discharged.

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[3] In fact, no physician, attending or otherwise, released claimant from all work after January 7, 1998. At most, claimant was released to modified work. (Exs. 6, 8-3, 9).

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

"(5) Notwithstanding ORS 656.268:

"* * * * *

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

[5] Subsequently, we decided *Ricardo Chavez*, 50 Van Natta 90 (1998), in which we determined that payment of TTD on the date of termination was not required to make ORS 656.325(5)(b) applicable. We found that, so long as a claimant was *entitled* to receive TTD when the carrier "ceased" payment of TTD under ORS 656.325(5)(b), the provisions of ORS 656.325(5)(b) were applicable. Our decision in *Chavez* does not make the reasoning in *Orazio* any less helpful in the present case. In this regard, here, claimant was not entitled to TTD before or after he was laid off due to reasons unrelated to any injury.

The same reasoning applies here. Claimant was performing his regular work duties and earning his regular wage when he left work on September 29, 1997. The reason claimant left work had nothing to do with an inability to work as a result of any work injury. Instead, claimant left work because he could not document his legal status to work in this country. Therefore, like the claimant in *Orazio*, claimant is not entitled to temporary disability benefits. *See Michael D. Wingo*, 48 Van Natta 2477 (1996); *aff'd Wingo v. DPR Construction*, 153 Or App 237 (1998) (Justice Armstrong dissenting); *Patricia K. Stodola*, 48 Van Natta 613 (1996); *Terri Link*, 47 Van Natta 1711 (1995).

We acknowledge that a claimant who has been fired from work, *but otherwise is in the work force*, is entitled to interim compensation if he or she "left work," i.e., was either absent from work due to the work injury or sustained diminished earning power attributable to the injury. *RSG Forest Products v. Jensen*, 127 Or App 247 (1994) (worker is entitled to interim compensation if he or she suffered loss of earnings as a result of the compensable injury, even if worker leaves job for reasons unrelated to compensable injury); *Nix v. SAIF*, 80 Or App 656 (1986) (claimant entitled to interim compensation for period during which claimant was unable to work due to his compensable injury, even though claimant had been terminated on the day of the injury); *see also Lisa R. Angstadt*, 47 Van Natta 981 (1995) (where claimant suffered diminished earning capacity after being terminated, she became entitled to interim compensation as of the date her diminished earning capacity began); *Jerilyn Hendrickson*, 46 Van Natta 1888 (1994) (where claimant suffered loss of earning capacity due to compensable injury, fact that she was fired for reasons unrelated to compensable injury did not preclude receipt of interim compensation).

Here, claimant did not leave work due to any work injury. Nonetheless, Dr. Stringham's "post-lay off" release to modified work could be considered evidence of diminished earning power due to the injury. To reach such a conclusion, however, would require overlooking the fact that a claimant must remain in the work force to be entitled to temporary disability. *Dawkins v. Pacific Motor Trucking*, 308 Or 254 (1989), *Cutright*, 299 Or at 296, 302; *Jensen*, 127 Or App at 250-51; *Bergstrom*, 77 Or App at 427. Furthermore, work force status is determined at the time of disability. *Dawkins*, 308 Or at 258; *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). Here, by the time claimant became disabled, he was unable to legally work in this country due to his status as an illegal alien. It follows that a person who cannot legally work is not in the work force. Therefore, claimant is not entitled to temporary disability benefits.

The dissent notes that, because the definition of a "worker" includes persons who are "unlawfully" employed, claimant's illegal alien status does not preclude him from being in the work force. ORS 656.005(30).[6] The dissent further notes that the legislature did not exclude illegal aliens from its definition of "worker," although it excluded several other classes of people from that definition. *Id.* Finally, the dissent notes that the very existence of ORS 656.325(5)(c), which by its terms recognizes that illegal aliens may receive temporary disability compensation under certain circumstances, evidences the legislature's intent not to exclude illegal aliens from the work force. From these points, the dissent infers that claimant was in the work force at the time in question and concludes that claimant is entitled to TPD from January 12, 1998 through January 26, 1998. Although we agree with these enumerated points, we nevertheless disagree with the inferences and conclusions the dissent draws in applying those points to the case at hand.

In the first place, the dissent's reliance on ORS 656.005(30) to find claimant in the work force at the time of disability is misplaced. True, claimant was a "worker" for the employer at one time, *i.e.*, he was unlawfully *employed* by the employer from the outset. But by the time claimant received the modified work release, he was *not* a worker. By that time, claimant had been terminated due to his immigration status, was not employed, and could not legally be employed. In other words, claimant may have had a compensable injury due to his status as a "worker" during his prior "unlawful" employment, but, by the time of his modified work release, he was no longer in the work force due to his stipulated unlawful immigration status.

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[6] As the dissent notes, ORS 656.005(30) defines a "worker," in relevant part, as:

"any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *, but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant."

Furthermore, we do not contend that the legislature intended to exclude illegal aliens from the work force under all circumstances. In this regard, as the dissent notes, ORS 656.325(5)(c) recognizes that such persons may receive temporary disability compensation *under certain circumstances*. *See Alfredo R. Hernandez*, 51 Van Natta 71 (1999) (applies ORS 656.325(5)(c) and determines that, when the claimant's attending physician approved a modified job, the insurer was authorized to cease TTD payments and commence TPD payments; applies OAR 436-060-0030(7), which provides the vehicle by which the rate of TPD payments can be calculated whether or not the modified job is available). Because temporary disability compensation is reserved for members of the work force, it follows that the legislature considered illegal aliens to be in the work force under certain circumstances.

Nevertheless, the important point to remember is that ORS 656.325(5)(c) never comes into play in the present case because claimant was never entitled to TTD. Thus, claimant's entitlement to temporary disability is determined by application of the workers' compensation law outside of ORS 656.325(5)(c) regarding an injured worker's entitlement to temporary disability. As discussed above, that law includes the requirement that a claimant be in the work force at the time of disability to be entitled to temporary disability. *Dawkins*, 308 Or at 258; *Cutright*, 299 Or at 296, 302; *Jensen*, 127 Or App at 250-51, *Kepford*, 100 Or App at 414. Moreover, claimant's immigration status, which was stipulated for the purposes of this matter to be unlawful, takes him out of the work force.

Contrary to the dissent's inference, however, that does not mean that no illegal alien would ever be entitled to temporary disability, nor does it mean that ORS 656.325(5)(c) would be rendered a nullity. In this regard, we find helpful the reasoning in *Kepford*, 100 Or App at 414-15, and *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, *on remand Arlene J. Koitzsch*, 46 Van Natta 1563, *on recon* 46 Van Natta 2265, *on recon* 46 Van Natta 2347 (1994).

In *Kepford*, the claimant left work due to low back pain and subsequently filed aggravation and new occupational disease claims. The employer denied both claims. Through litigation that spanned several years, it was finally determined that the claimant's low back claim was compensable as an occupational disease. In the interim, the claimant had retired and began receiving retirement benefits from the employer and social security benefits. The employer failed to pay any temporary disability benefits, reasoning that the claimant was not entitled to those benefits because he had retired.

Applying *Dawkins v. Pacific Motor Trucking*, 308 Or at 258, the *Kepford* court held that the critical time for determining whether a claimant has withdrawn from the work force is at the time of his disability. 100 Or App at 414. The court found that the claimant was working and was, therefore, a member of the work force when he became disabled by his occupational disease. Thus, the claimant was entitled to receive temporary disability benefits. It did not matter that he retired or had withdrawn from the work force after that time. The court reasoned that, under *Dawkins*, the claimant was not required to show that he remained in the work force. 100 Or App 414-15.

In *Koitzsch*, the court determined that *former* ORS 656.245(3)(b)(B)[7] did not permit the Board to consider impairment findings of an insurer-arranged medical examiner (IME) in determining the claimant's permanent disability award. Instead, the court determined that impairment findings must come from the attending physician. Because the Board violated *former* ORS 656.245(3)(b)(B) by considering the impairment findings of an IME, the court remanded the case to the Board to correctly apply *former* ORS 656.245(3)(b)(B). 125 Or App at 516.

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[7] The language the court interpreted in *former* ORS 656.245(3)(b)(B) remains the same, but is now found at ORS 656.245(2)(b)(B). That language provides:

> "Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

On remand, we initially agreed with the insurer that Dr. Johnson, the claimant's treating physician in Washington state did not qualify as an attending physician under *former* ORS 656.005(12)(b)(A)[8] because there was no evidence that he was licensed to practice medicine in Oregon. Therefore, because no medical arbiter had been appointed and there were no impairment findings from an attending physician, we found that the claimant failed to establish entitlement to a permanent disability award. 46 Van Natta at 1565. The claimant requested reconsideration.

On reconsideration, we found that the insurer's objection to Dr. Johnson's status as claimant's "attending physician" was untimely. In this regard, the insurer did not raise that objection until its respondent's brief. In addition, the insurer itself had treated Dr. Johnson as the claimant's attending physician throughout the claim. Considering the insurer's acquiescence to the claimant's implicit and explicit assertions concerning Dr. Johnson's status as her "attending physician" and its own reliance on that status, we declined to consider the insurer's "post-hearing" objections to Dr. Johnson's impairment findings to the extent those objections were based on an alleged failure to satisfy the statutory definition of an "attending physician." 46 Van Natta at 2266. We found that the insurer conceded that Dr. Johnson was the claimant's "attending physician" (regardless of whether the record would support such a finding). 46 Van Natta at 2267. Therefore, we proceeded to rate the claimant's permanent impairment based on Dr. Johnson's findings.

The reasoning in *Kepford* and *Koitzsch* applies to the situation where an illegal alien leaves work due to a work injury (or occupational disease) and later is terminated due to his or her illegal alien status. First, pursuant to *Kepford*, since work force status is determined *at the time of disability*, a worker who leaves work due to a work injury is necessarily in the work force. A worker's subsequent termination or failure to be offered modified work because the worker is not able to legally be employed in the United States due to his or her illegal alien status is analogous to the *Kepford* claimant's withdrawal from the work force *after* being disabled due to a work injury.[9] The determinative factors are that both claimants were in the work force at the time of their disability and left work due to their work injury. Neither need show that he or she remained in the work force to be entitled to temporary disability benefits.

Second, like the insurer in *Koitzsch*, who could not be heard to argue that a physician whom it had treated as an attending physician without objection did not satisfy the statutory requirements of an "attending physician" when it came to determining the worker's permanent disability, an employer who benefited from a worker's labor without objection cannot be heard to argue that that worker, due to his

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[8] *Former* ORS 656.005(12)(b) provided:

"(b) 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury and who is:

"(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners of the State of Oregon or a board certified oral surgeon licensed by the Oregon Board of Dentistry."

We note that the legislature amended this statute in 1997 to include within the definition of an attending physician any "similarly licensed doctor or physician in any country or in any state, territory or possession of the United States."

[9] In contrast, claimant's situation is similar to that of a worker who withdraws from the work force *before* becoming disabled by a work injury. Such a worker, even if he or she is legally able to work in the United States, is *not* entitled to temporary disability. *James F. Fowlkes*, 48 Van Natta 771 (1996) (claimant not entitled to temporary disability when he was not disabled when he voluntarily withdrew from the work force but became disabled due to the compensable injury *after* he left the work force). Here, admittedly, claimant did not *voluntarily* leave the work force. Nevertheless, under federal immigration law, claimant's stipulated immigration status prevents him from legally working in the United States. Thus, claimant has essentially been withdrawn from the work force, although that withdrawal was by mandatory, "statutory" means.

We note that the *Dawkins* Court explained that a worker is deemed to be in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; (2) not employed, but willing to work and is seeking work; or (3) willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. 308 Or at 258. But *Dawkins* and its progeny are distinguishable in that they did not address the situation presented in the current case: a worker who cannot legally work in the United States due to federal immigration law and who becomes disabled several months after being terminated due to his illegal alien status.

or her status as an illegal alien, never qualified as a member of the work force in the first place and, therefore, is not entitled to any temporary disability. In other words, by initially employing an illegal alien, the employer has treated him or her as a worker and benefited from his or her labor. Under those circumstances, the employer cannot later argue that the illegal alien was never a worker.

Such reasoning is consistent with ORS 656.325(5)(c), which by its terms allows the payment of temporary disability to illegal aliens under certain circumstances. Nevertheless, as explained above, this claimant is not entitled to temporary disability benefits.

Finally, because we find that claimant is not entitled to temporary disability benefits, we need not address claimant's arguments regarding the rate at which such benefits should be paid.

ORDER

The ALJ's order dated March 26, 1998 is affirmed.

Board Member Biehl dissenting.

The majority acknowledges that a claimant who has been fired from work, but otherwise is in the work force, is entitled to interim compensation if he or she "left work," *i.e.*, was either absent from work due to the work injury or sustained diminished earning power attributable to the injury. *RSG Forest Products v. Jensen*, 127 Or App 247 (1994). Nevertheless, although claimant's circumstances fit this very scenario, *i.e.*, claimant was fired from work due to his illegal alien status but later was released to modified work by Dr. Stringham, the majority concludes that claimant is not entitled to TPD because he is not in the work force. They reason that, due to his illegal alien status, claimant cannot legally be employed and a person who cannot legally be employed is necessarily not a member of the work force. Because I disagree with this reasoning, I respectfully dissent.

I agree with the majority that, by its terms, ORS 656.325(5)(c) does not apply to this case. I further agree that temporary disability is reserved for workers and not those who have withdrawn from the work force. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296 (1985). But there is no evidence that claimant has withdrawn from the work force. Furthermore, in concluding that a person who cannot legally be employed is necessarily not a member of the work force, the majority overlooks the very definition of a "worker." ORS 656.005(30) defines a "worker," in relevant part, as:

> "any person, including a minor *whether lawfully or unlawfully employed*, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * * , but does not include any person whose services are performed as an inmate or ward of a state institution or as part of the eligibility requirements for a general or public assistance grant." (Emphasis added).

Thus, by definition, a "worker" includes persons who are unlawfully employed. Therefore, contrary to the majority's conclusion, claimant's illegal alien status does not preclude him from being in the work force. Moreover, in ORS 656.005(30) the legislature explicitly excluded several classes of people from its definition of "worker." But it is important to note that the legislature did *not* exclude illegal aliens from that definition. Furthermore, the very existence of ORS 656.325(5)(c), which by its terms recognizes that illegal aliens may receive temporary disability compensation under certain circumstances, evidences the legislature's intent not to exclude illegal aliens from the work force.

Finally, if the majority's theory were pursued to its logical conclusion, no illegal alien would ever be entitled to temporary disability, which is in direct contravention of ORS 656.325(5)(c). In this regard, under the majority's reasoning, by definition, an illegal alien can never be legally employed in the United States and, thus, cannot be a member of the work force. Because only members of the work force are entitled to temporary disability, whether total or partial, it follows that no illegal alien would ever be entitled to TTD. Since entitlement to TTD is a prerequisite to applying ORS 656.325(5)(c) and no illegal alien could meet that prerequisite under the majority's theory, ORS 656.325(5)(c) would be rendered a nullity. We may not render a statute a nullity.

The majority attempts to resolve this dilemma by applying *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990), and *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, *on remand Arlene J. Koitzsch*, 46 Van Natta 1563, *on recon* 46 Van Natta 2265, *on recon* 46 Van Natta 2347 (1994), by analogy and determining that an illegal alien is in the work force by virtue of the fact that the employer hired him or her, *if* he or she becomes disabled before being terminated due to his or her status as an illegal alien. But the majority offers no reason why that same analogy does not apply to extend an illegal alien's work force status to the time he or she becomes disabled after being terminated due to his illegal alien status, so long as the worker remains willing to work. In other words, no matter when the worker becomes disabled, the fact remains that the employer hired the illegal alien and benefited from his or her labor. Why should the employer be able to avoid its responsibility to an injured worker and hide behind federal immigration laws when that same employer did not comply with the federal immigration laws when it hired the illegal alien in the first place? I say the employer should not be allowed to avoid its responsibility in such a manner.

Here, claimant clearly remained willing to work. He actually obtained work at a lumber mill after being terminated by the present employer. Thus, I would find that claimant remained in the work force, despite his illegal alien status. *Koitzsch*, 46 Van Natta at 2266.

For the above reasons, I reject the majority's theory and conclude that, pursuant to Dr. Stringham's release to modified work, claimant is entitled to TPD from January 12, 1998 through January 26, 1998. Furthermore, I would find that, because claimant was not earning any wages during the period in question, his TPD benefits should be calculated using his TTD rate. See my dissent in *Alfredo R. Hernandez*, 51 Van Natta 71 (1999).

In the Matter of the Compensation of
LUZVIMINDA P. ANONUEVO, Claimant
WCB Case Nos. 97-08236 & 97-04120
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The self-insured employer requests review of that portion of the Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's aggravation claim for a right shoulder condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the employer's denial of her occupational disease claim for a right shoulder condition. Claimant also asserts that a medical report submitted by the employer should not be considered part of the record on appeal. On review, the issues are evidence, aggravation and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. We do not adopt the ultimate findings of facts. After the last paragraph of the findings of fact on page 2, we add the following paragraph:

> "On February 16, 1998, Dr. Neitling performed surgery on claimant's right shoulder. (Ex. 59B). His post-operative diagnosis was chronic tendinitis with impingement, right shoulder, synovitis of the right acromioclavicular joint and a partial rotator cuff tear. (*Id.*)"

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, the parties agree that the ALJ admitted Exhibit 63, a March 5, 1998 letter from Dr. Neitling, into evidence. However, the record indicates that on March 26, 1998, the employer submitted a March 17, 1998 report from Dr. Neitling (also labeled Exhibit 63) for admission into evidence.

Claimant contends that the March 17, 1998 report from Dr. Neitling, which was erroneously numbered Exhibit 63, was submitted after the ALJ closed the record and should not be considered a part of the record on appeal.

The ALJ's order indicates that the record closed on March 25, 1998. In the employer's March 26, 1998 letter to the ALJ, it submitted a March 17, 1998 report from Dr. Neitling (labeled Exhibit 63) for admission into evidence. The employer's attorney asserted that he had not received the report until March 24, 1998 and, therefore, it was not producible at the time of the March 10, 1998 hearing. The employer's attorney also explained that, because the report contained Dr. Neitling's post-operative impressions, the report was not producible until he did a post-surgical evaluation.

The ALJ did not refer to the employer's March 26, 1998 submission in the Opinion and Order. Nevertheless, the ALJ admitted "Exhibit 63," which the parties agree referred to Dr. Neitling's March 5, 1998 letter. In light of such circumstances, the record supports a conclusion that Dr. Neitling's March 5, 1998 letter was admitted into evidence, but Dr. Neitling's March 17, 1998 report was not admitted.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

Under OAR 438-007-0025, the ALJ may reopen the record and reconsider his or her decision based upon newly-discovered evidence where the motion to reconsider states the nature of the new evidence and explains why it could not have been reasonably discovered and produced at hearing. In this case, we find no abuse of discretion. Dr. Neitling performed surgery on claimant's right shoulder on February 16, 1998. (Ex. 59B). We find no evidence that the employer exercised due diligence in obtaining Dr. Neitling's post-surgical evaluation before the March 10, 1998 hearing. *Compare Herbert Gray*, 49 Van Natta 1781 (1997) (the claimant did not seek treatment from Dr. Switlyk until after the hearing; the ALJ did not abuse his discretion in reopening the record for receipt of Dr. Switlyk's report). Under these circumstances, we conclude that the ALJ did not abuse his discretion in declining to admit the letter into evidence. In any event, the record already contains two post-surgical reports from Dr. Neitling. (Exs. 61, 63). We conclude that consideration of Dr. Neitling's March 17, 1998 report will not likely affect the outcome of the case.

Occupational Disease Claim

At the time of hearing, claimant had worked for the employer for approximately eight years as a footwear component operator. In 1993 and 1994, she had a gradual onset of pain in her right shoulder and right wrist. The employer accepted a nondisabling claim of "strain right shoulder and right wrist." (Ex. 8). On October 28, 1994, Dr. Barlow reported that claimant was medically stationary without permanent impairment. (Ex. 20). She returned to regular work activities.

In 1996, claimant had a gradual onset of right shoulder pain that continued to increase in severity. On January 22, 1997, she signed an "801" form that referred to right shoulder pain. (Ex. 21). On April 16, 1997, the employer denied the claim on the ground that claimant's work activities were not the major contributing cause of her right shoulder condition. (Ex. 38). On February 16, 1998, Dr. Neitling performed surgery on claimant's right shoulder. (Ex. 59B). His post-operative diagnosis was chronic tendinitis with impingement, right shoulder, synovitis of the right acromioclavicular joint and a partial rotator cuff tear. (*Id.*)

The ALJ upheld the employer's denial of claimant's current right shoulder condition because there was no medical evidence that claimant had suffered a new injury or occupational disease in 1996.

On review, claimant argues that her work activities at the employer were the major contributing cause of her current right shoulder conditions. To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of those conditions. 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).

Claimant asserts that ORS 656.802(2)(b) applies to her "new" occupational disease claim and the only preexisting condition was the 1994 injury claim. Because claimant relies on all of her employment activities with the employer to establish compensability, we do not treat the 1994 claim as a "preexisting" condition. This is an initial occupational disease claim for the conditions of right shoulder chronic tendinitis with impingement, synovitis of the right acromioclavicular joint and a partial rotator cuff tear. Therefore, the onset of this occupational disease claim is December 1990 (Ex. 21), when claimant began working for the employer. *See New Portland Meadows v. Dieringer*, 153 Or App 383, *modified* 157 Or App 619 (1998). Thus, we must determine whether claimant's occupational disease claim is based on the worsening of a preexisting disease or condition.

The employer contends that claimant has a Type II or III acromion that "predisposed" her to impingement. Even if we assume that claimant has an acromion that predisposed her to impingement, there is no evidence in the record that it preexisted her employment with the employer. Furthermore, we are not persuaded that claimant's acromion is an important factor in her occupational disease claim. Dr. Neitling reported that the x-rays showed no particular abnormality or hooking of the anterior acromion. (Ex. 54A). Under these circumstances, we find that claimant's occupational disease claim is not based on the worsening of her acromion.

Some of the earlier medical reports indicated claimant had degenerative joint disease in her right shoulder. Dr. Young reported that claimant's bone scan was "suggestive" of degenerative joint disease. (Ex. 35). In a later report, however, he agreed that a definitive diagnosis of arthritis was not possible without an arthroscopy. (Ex. 43-2). Drs. Pierson and Fuller also agreed that claimant may have arthritis or degenerative joint disease. (Exs. 52-19, -24, 55-2).

Despite the medical reports referring to possible degenerative conditions, we are more persuaded by Dr. Neitling's opinion. Before claimant's shoulder surgery, Dr. Neitling agreed that, based on his examinations of claimant and his review of the bone scans and MRI scan, claimant was not suffering from degenerative joint disease of her right shoulder. (Ex. 59-2). In his February 16, 1998 surgical report, Dr. Neitling reported that there were no degenerative changes of the acromioclavicular joint. (Ex. 59B-2). After claimant's surgery, Dr. Neitling concluded that there was no evidence of any significant preexisting disease in the shoulder. (Ex. 63-1). Rather, he felt that the findings in the shoulder appeared reactive to the primary inflammatory process. (*Id.*) He also disagreed with Dr. Fuller's comments that claimant was getting referred pain from degenerative facet arthritis at C3-4. (Ex. 63-1). Dr. Neitling did not believe that the facet arthritis at C3-4 was at all consistent with the severity of claimant's right shoulder problem. (*Id.*)

As the treating surgeon, Dr. Neitling had the opportunity to examine claimant's right shoulder pathology, including any degeneration, during surgery and, thus, had the most complete information upon which to base his opinion. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988). Based on Dr. Neitling's opinion, we conclude that claimant's occupational disease claim is not based on the worsening of a preexisting degenerative disease or condition.

In addition, we agree with Dr. Neitling's opinion that claimant did not have a systemic problem that was causing her shoulder condition. On March 27, 1997, Drs. Fuller and Gardner said it was "possible" claimant had a systemic condition that was causing some bone discomfort. (Ex. 37-4). Dr. Fuller reiterated that opinion in a later report. (Ex. 55-2). On the other hand, Dr. Neitling felt that, based on his examinations and claimant's response to the subacromial injection, she did not have a systemic problem. (Ex. 50-2). In a later report, Dr. Neitling explained that if claimant had systemic disease, he would expect to see symptoms bilaterally and in other major joints. (Ex. 59-2, -3). He did not agree with Dr. Fuller's conclusion that claimant had a systemic problem that related to her right shoulder pathology and, instead, Dr. Neitling felt that claimant had impingement syndrome. (*Id.*)

Finally, we are not persuaded by Dr. Fuller's conclusion that claimant had a traumatic avulsion of the supraspinatus tendon at some point in her life. (Ex. 62). Dr. Fuller reported that it was medically probable that claimant's supraspinatus avulsion and acromioclavicular joint arthritis resulted from a traumatic injury such as a fall on ice or something similar. (*Id.*) We agree with the ALJ that there is no evidence in the record that claimant ever fell on her right shoulder. Dr. Fuller's opinion regarding a traumatic injury is not persuasive.

We conclude that claimant's occupational disease claim is not based on the worsening or combining of a preexisting disease or condition. Therefore, she must establish compensability under ORS 656.802(2)(a) and must prove that her employment conditions with the employer were the major contributing cause of her right shoulder condition. Claimant relies on Dr. Neitling's opinion to establish compensability.

Dr. Neitling first examined claimant on July 22, 1997, diagnosing chronic impingement syndrome, right shoulder, with rotator cuff tendinitis. (Ex. 45-2). He felt her current condition was related to the 1994 claim, which had never resolved. (Ex. 45-3). He concluded that claimant's employment activities were the sole cause of the initial 1994 condition and her continued symptoms. (*Id.*) Dr. Neitling found no outside activities or preexisting conditions that played a part in her present symptom complex. (*Id.*)

In a letter to the employer on September 25, 1997, Dr. Neitling reported that the injection of claimant's right shoulder confirmed his diagnosis of a chronic tendinitis/impingement problem. (Ex. 50-1). He explained that claimant developed rotator cuff tendinitis as a result of work-related activities, which included repetitive use of her arms. (*Id.*) He noted that claimant's arms were out in front of her for most of the work shift. (*Id.*)

In a concurrence letter from claimant's attorney, Dr. Neitling agreed that claimant's employment with the employer was more than 50 percent responsible for her chronic impingement syndrome with rotator cuff tendinitis. (Ex. 59-1). Dr. Neitling considered, and rejected, the possible contribution from degenerative conditions and systemic disease. (Ex. 59-2). *See Dietz v. Ramuda,* 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (determination of major contributing cause involves evaluating the relative contribution of different causes and deciding which is the primary cause). Dr. Neitling had reviewed claimant's job description and agreed that inflating 200 air bladders an hour with her arms abducted was the likely etiology of her right shoulder impingement. (Ex. 59-3). He explained that repetitive movement of claimant's arms from side to side at even a slight abduction would be sufficient to cause claimant's chronic right shoulder impingement. (*Id.*) He found no significant off-work causative factors and reiterated that claimant's work activities were the sole cause of her right shoulder condition. (Ex. 59-2, -3).

After claimant's shoulder surgery on February 16, 1998, Dr. Neitling reported that the surgical findings were consistent with his earlier opinions on causation. (Ex. 61). He believed that claimant's repetitive work-related activities were the major contributing cause of the impingement condition and chronic breakdown of the rotator cuff. (*Id.*) He found no evidence of any preexistent or combined condition. (*Id.*)

On March 5, 1998, Dr. Neitling explained that claimant's impingement syndrome/tendinitis was the direct result of chronic repetitive work activities at the employer. (Ex. 63-1). He explained that claimant initially developed rotator cuff tendinitis as a consequence of her work activities, which developed into impingement syndrome. (*Id.*) He said that there was continued irritation of the subacromial bursa and the rotator cuff and the pathologic process led to a tearing of the rotator cuff. (Ex. 63-1, -2).

We are persuaded by Dr. Neitling's opinion because it is well-reasoned and based on accurate and complete information. *See Somers v. SAIF,* 77 Or App 259 (1986). Furthermore, as claimant's treating surgeon, we find no reasons not to rely on his opinion. *See Argonaut Insurance Co. v. Mageske,* 93 Or App at 702; *Weiland v. SAIF,* 64 Or App 810, 814 (1983).

Although the employer relies on the opinions of other physicians, we note that only one of those physicians, Dr. Fuller, had an opportunity to review Dr. Neitling's surgical report. As the employer points out, there was some contention among the physicians as to the nature of claimant's condition and the shoulder surgery cleared up most of this debate. For the following reasons, we do not find Dr. Fuller's opinion persuasive.

On March 27, 1997, Drs. Fuller and Gardner reported that claimant did not have degenerative arthritis of her neck or right shoulder and they felt it was possible she had a systemic condition that caused some bone discomfort. (Ex. 37-4). They were of the "firm opinion" that her condition did not

relate to her work activities. (Ex. 37-5). On October 29, 1997, Dr. Fuller reviewed additional records and he continued to believe that claimant's discomfort related to a systemic problem. (Ex. 55-2). He also changed his mind and agreed with Dr. Young that claimant's findings may represent early arthritis. (*Id.*) On February 23, 1998, Dr. Fuller had reviewed claimant's bone scan and determined that she had two sources of right shoulder discomfort: referred pain from degenerative facet arthritis at C3-4 and pain from a lesion within the right humeral head. (Ex. 60). After reviewing claimant's surgical report, Dr. Fuller believed that claimant had previously sustained a traumatic avulsion of the supraspinaus tendon. (Ex. 62). He concluded that claimant's supraspinatus avulsion and acromioclavicular joint arthritis had resulted from a traumatic injury. (*Id.*)

We agree with the ALJ's conclusion that Dr. Fuller's reports are inconsistent and unpersuasive. Although he initially said that claimant did not have degenerative arthritis of her neck or right shoulder, he later said she had degenerative facet arthritis at C3-4 and acromioclavicular joint arthritis. As we explained earlier, we are more persuaded by Dr. Neitling's reports, which rejected the possible contribution from degenerative conditions. (Ex. 59-2). In addition, claimant testified that she had not experienced right shoulder discomfort before working for the employer and had not previously injured her right shoulder. (Tr. 15, 37). We agree with the ALJ that there is no evidence to support Dr. Fuller's conclusion that claimant's right shoulder condition had resulted from a traumatic injury.

In addition, we do not find Dr. Young's opinion on causation persuasive. Dr. Young believed that claimant had right shoulder degenerative joint disease. (Exs. 35, 43). In a deposition, he felt that claimant's bone scan showed arthritic change to both shoulders, including the AC joint. (Ex. 56-13). He also testified that he was not convinced claimant had impingement syndrome. (Ex. 56-18, -19). Dr. Neitling's surgery confirmed that claimant had impingement syndrome. Moreover, as we explained earlier, we are persuaded by Dr. Neitling's reports that claimant did not have degenerative joint disease in her right shoulder (Ex. 59-2), and he found no degenerative changes of the acromioclavicular joint during surgery. (Ex. 59B-2).

Similarly, we are not persuaded by Dr. Pierson's opinion on causation. He testified that claimant had signs of degenerative joint disease in the glenohumeral joint and AC joint. (Ex. 52-19). He felt that the bone scan provided good evidence she had degenerative joint disease. (Ex. 52-27). Dr. Pierson did not believe degenerative disease was work-related. (Ex. 52-36, -38, -39). Because Dr. Pierson incorrectly believed that claimant had degenerative joint disease, we are not persuaded by his opinion.

In sum, we are most persuaded by Dr. Neitling's well-reasoned opinion. As the treating surgeon, Dr. Neitling had the opportunity to examine claimant's right shoulder pathology during surgery and had the most complete information upon which to base his opinion on causation. *See Argonaut Insurance Co. v. Mageske*, 93 Or App at 702. Dr. Neitling's opinion is supported by Dr. Switlyk's comment that claimant's repetitive use of her arm seemed to play "such a role in causing the severity of her symptoms." (Ex. 58-3). Based on Dr. Neitling's opinion, we conclude that claimant has established that her work activities at the employer were the major contributing cause of her right shoulder conditions, *i.e.*, right shoulder chronic tendinitis with impingement, synovitis of the right acromioclavicular joint and a partial rotator cuff tear.

Aggravation

On review, claimant contended that her "right shoulder conditions are compensable as either an aggravation of the 1994 claim or a new occupational disease." (Appellant's br. at 18). Based on this acknowledgement and because we have found claimant's conditions constitute a compensable occupational disease claim, we reverse that portion of the ALJ's order that found claimant's aggravation claim compensable.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the occupational disease claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the occupational disease claim is $5,500, payable by the self-insured

employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant's attorney is not entitled to an attorney fee for services on review regarding the aggravation claim. Furthermore, the ALJ's $4,000 attorney fee award concerning the aggravation denial is reversed.

ORDER

The ALJ's order dated April 1, 1998 is reversed The employer's denial of claimant's aggravation claim is reinstated and upheld. The employer's denial of the occupational disease claim is set aside and the claim is remanded to the employer for processing according to law. The ALJ's $4,000 attorney fee award for the aggravation claim is also reversed. For services at hearing and on review concerning the occupational disease claim, claimant's attorney is awarded $5,500, payable by the self-insured employer.

In the Matter of the Compensation of
TOBY R. KINZINGER, Claimant
WCB Case No. 98-02648
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's left hip injury claim; and (2) assessed an attorney fee of $3,500. On review, this issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that, in June 1997, claimant slipped and fell at work. Relying on the opinion of claimant's current treating physician, Dr. Voeller, internal medicine specialist, the ALJ concluded that claimant proved compensability of a left hip condition. On review, SAIF contests this conclusion, asserting that Dr. Voeller's opinion is not sufficiently persuasive to carry claimant's burden of proof.

Claimant first sought treatment in October 1997, and was referred to orthopedist, Dr. Soot, in November 1997. Dr. Soot initially diagnosed a femoral neck fracture and attributed the condition to the June 1997 work incident. (Ex. 8). But after a bone scan failed to show any injury in the hip, pelvis, or lumbar spine, Dr. Soot found that claimant's symptoms were not due to a "specific mechanical injury." (Ex. 15). In particular, Dr. Soot found that claimant's left hip symptoms were of "undetermined etiology" and thought that any soft tissue injury sustained in June 1997 would have resolved by the time Dr. Soot examined claimant in November 1997. (Ex. 17-1).

In March 1998, claimant began treating with Dr. Voeller, who concurred with a letter drafted by claimant's attorney stating that claimant "suffered a soft tissue injury at the time of his slip and fall which accounts for his ongoing left hip pain." (Ex. 19-1). The letter further stated that "the fall at work is the sole cause of this soft tissue injury" and Dr. Voeller was "unaware of any other causative factors or pathology that would account for these symptoms." (*Id.*)

Dr. Voeller also agreed with a subsequent letter from claimant's attorney stating that he did not agree with Dr. Soot's opinion because "a soft tissue injury can take longer than a fracture to heal." (Ex. 20). According to the letter, Dr. Voeller found it "probable given the history of the work injury and the objective evidence of reproducible pain upon examination that the work injury remains the major cause of [claimant's] need for treatment." (*Id.*)

In evaluating the persuasiveness of medical opinions, we rely on those that are well-reasoned and based on an accurate history. *See Somers v. SAIF*, 77 Or App 259 (1986). Furthermore, ORS 656.266 precludes a worker from proving compensability solely by disproving other possible explanations of how the injury or disease occurred, which requires that there be some affirmative evidence that the condition is caused by the claimant's work exposure. *Bronco Cleaners v. Velasquez*, 141 Or App 295 (1996)

Here, Dr. Voeller provides no explanation to support his opinion that the June 1997 work incident caused claimant's left hip symptoms. In particular, Dr. Voeller does not indicate how the mechanics of the injury could result in claimant's condition. Moreover, other than simply disagreeing with Dr. Soot's opinion that any strain injury would have healed by November 1997, Dr. Voeller does not explain the persistence of claimant's symptoms and why, in his particular case, a strain injury continues to persist nearly nine months after the work incident. Finally, by stating that he was "unaware of any other causative factors," Dr. Voeller seems to be basing his opinion only on the absence of potential contributors without giving any affirmative evidence to support a causative relationship between the work event and claimant's left hip injury.

In light of these inadequacies in Dr. Voeller's opinion and because it is contradicted by claimant's first treating physician, we find the medical opinions at best to be in equipoise. Thus, we agree with SAIF that Dr. Voeller's opinion is not sufficiently persuasive to carry claimant's burden of proving compensability.

Attorney Fees

Because we have found the claim not compensable, claimant is not entitled to an assessed attorney fee. *See* ORS 656.386(1). Consequently, we need not address that portion of the ALJ's order awarding the attorney fee.

ORDER

The ALJ's order dated October 13, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Biehl dissenting.

I disagree with the majority that claimant failed to prove compensability. I agree with the ALJ that Dr. Voeller's opinion carries claimant's burden of proof. Dr. Voeller had an accurate history and explained why the work injury caused claimant's need for treatment. Thus, I find no persuasive reasons for not deferring to his opinion. *See Weiland v. SAIF*, 56 Or App 810 (1983). Because the majority comes to a contrary conclusion, I dissent.

In the Matter of the Compensation of
GREGORY S. ALTON, Claimant
WCB Case No. 98-04318
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that awarded claimant 74 percent (236.8 degrees) unscheduled permanent disability for a head injury, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant, a roofer, was injured on August 1, 1995, when he fell approximately 12 to 15 feet through a skylight onto a concrete bathroom floor. SAIF accepted a nasal fracture, a non-displaced left zygomaticomaxillary complex fracture, a basilar skull fracture, a mild closed head injury and bilateral periorbital ecchymosis. (Ex. 10). A Notice of Closure dated February 23, 1998 awarded temporary disability but no permanent disability. (Ex. 33). Claimant requested reconsideration. (Ex. 35). Drs. Holden, Williams and Krump performed arbiter examinations. (Exs. 40, 41, 43). Although those reports were not available when the May 22, 1998 Order on Reconsideration issued, they were made part of the record on reconsideration and were admitted at hearing. (Ex. 42). The ALJ considered the arbiter examinations and concluded that claimant was entitled to an unscheduled permanent disability award of 74 percent.

SAIF argues that claimant failed to prove that he has permanent impairment as a result of the August 1, 1995 injury. SAIF contends that the ALJ erred by relying on Dr. Williams' report. We disagree.

Under OAR 436-035-0007(13) (WCD Admin. Order 96-072), where a medical arbiter is used on reconsideration, "impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." After our *de novo* review, we adopt the ALJ's reasoning and conclusion that the opinion of Dr. Williams, neurosurgeon, who served as the medical arbiter, establishes that claimant was entitled to an unscheduled permanent disability award.

Alternatively, SAIF argues that, if claimant does have any impairment, it should be Class 1 (10 percent impairment), rather than Class III (50 percent). We disagree.

OAR 436-035-0390(10) relates to impairment for injuries that have resulted in brain damage. The criteria for Class III (50 percent impairment) provides:

> "The worker functions at a Rancho Los Amigos Scale of 7 (e.g. the worker is alert and oriented, behavior is appropriate but the worker has impaired judgment and/or mild memory deficit) and the worker may require assistance or supervision in order to perform some activities of daily living. Language deficit is mildly-moderate (e.g. language comprehension or production is often not adequate for daily living). Emotional disturbances or personality changes are moderate, disproportionate to the stress or situation, are present at all times and significantly impair the worker's ability to relate to others or to live with others. Episodic sleep disturbances and/or lethargy are moderate (e.g. they frequently interfere with daily living). If there is an episodic neurologic disorder, it is not completely controlled. It markedly interferes with daily living. The worker cannot operate industrial machinery."

Dr. Williams, neurosurgeon, determined that claimant had Class III impairment. (Ex. 40-4). He reported that claimant seemed to have a significant gap in his past recent memory and at times had difficulty doing the task he was asked to perform. (Ex. 40-3). He was able to read but had to read something two or three times before he understood it. (*Id.*) Claimant had sleep disturbance and was unable to sleep on some occasions. (*Id.*) He used to be able to work on motorcycles, but now gets confused and has difficulty. (*Id.*) Claimant had daily headaches, which rate about 7 on a scale of 0 to 10. (*Id.*) He had been told he had a personality change after the accident. (*Id.*) Claimant did not have

a bank account and kept his money at home. (Id.) Dr. Williams did not consider claimant safe to operate industrial machinery. (Ex. 40-4). He concluded that claimant had impaired judgment and mild memory deficit and his language was mildly affected. Based on Dr. Williams' findings, we agree with the ALJ that claimant has Class III impairment.

On review, claimant renews his argument that he is entitled to a Class IV rating, which would entitle to him to 100 percent unscheduled permanent disability for his brain injury. For the reasons explained by the ALJ, we agree that claimant's deficits as described in this record do not place him within the Class IV criteria.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 25, 1998 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the SAIF Corporation.

In the Matter of the Compensation of
EDWARD J. ANDREWS, Claimant
WCB Case No. 98-05370
ORDER ON REVIEW
VavRosky, MacColl, Olson, et el, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Davis' order that dismissed his hearing request concerning the self-insured employer's denial of his occupational disease claim for carpal tunnel syndrome, on the basis that the hearing request was untimely. On review, the issue is timeliness of the hearing request and, potentially, compensability.

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

In November 1997, claimant filed a claim for left carpal tunnel syndrome. The employer arranged for him to attend an insurer-arranged medical examination at 1:45 p.m. on February 3, 1998. Claimant arrived for the appointment at 1 p.m. and was advised that the doctor was running late. At 2:22 p.m., claimant left the doctor's office because he felt obligated to run errands related to an upcoming business trip. He asked the staff to reschedule the appointment.

On February 9, 1998, while claimant was out of town, the employer issued a denial of claimant's claim based on a lack of medical evidence supporting the claim. The denial, which was sent via certified mail, return receipt requested, noted that claimant had left the IME appointment without seeing the doctor.

Claimant signed for and received the denial letter on February 13, 1998. He read the letter and understood that his claim had been denied, but believed that the matter would be resolved by his attending the IME, which had been rescheduled for April 11, 1998.

Claimant was examined by Dr. Laycoe on April 11, 1998. In June 1998, claimant called the employer's claim processing agent to check on the status of his claim. He was advised that the claim had been denied for lack of medical evidence.

On July 1, 1998, claimant wrote to the Workers' Compensation Board challenging the employer's denial. The letter was treated as a request for hearing.

The ALJ found that claimant had not appealed the denial letter within 60 days of the date of mailing and did not show good cause for his failure to request a hearing within the 60 day period. On review, claimant asserts that he mistakenly assumed that the claim was being processed when his IME had been rescheduled.

As the ALJ found, ORS 656.319(1) provides that a hearing shall not be granted unless the request for hearing is filed not later than the 60th day after mailing of the denial to the claimant or, not later than the 180th day after mailing of the denial so long as the claimant establishes "good cause" for failing to file the request by the 60th day.

Here, claimant did not file his request for hearing within the 60 day period, but he did challenge the employer's denial within 180 days of the date of mailing. Consequently, claimant must show "good cause" for his failure to file his request. *See Cogswell v. SAIF*, 74 Or App 234 (1985). In this context, "good cause" means "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1). *Hempel v. SAIF*, 100 Or App 68, 70 (1990). Lack of diligence does not constitute good cause. *Cogswell*, 74 Or App at 237. Moreover, confusion regarding the contents of a denial does not, without reasonable diligence, constitute good cause. *See, e.g., Bertha Vega*, 45 Van Natta 378 (1993) (claimant's inability to understand English did not establish good cause, nor did claimant's daughter's mistaken translation of denial letter); *Tuan A. Ho*, 45 Van Natta 2413 (1993).

Like the ALJ, we appreciate that claimant mistakenly assumed that the denial was meaningless because he had rescheduled and planned to attend the IME. But, we find an absence of any evidence supporting claimant's assumption. For instance, there is no proof that claimant was advised by a representative of the employer or employer's claims processor that the matter was being deferred, or that the claim would be accepted after his attendance at the second IME. Thus, claimant has not shown good cause for his failure to timely file a request for hearing on the denial.

Indeed, we have consistently found that, where there is no evidence the claimant was mislead, a claimant's misunderstanding of a carrier's claims processing actions does not establish good cause under amended ORS 656.319(1)(b). *See, e.g., Randall Davis*, 48 Van Natta 369 (1996) (the claimant's mistaken belief that his left knee injury claim would be processed as part of his left heel claim did not constitute good cause for the late filing of a request for hearing); *Wayne A. Moltrum*, 47 Van Natta 955 (1995) (the claimant's former attorney's mistaken belief that carrier had already been ordered to accept the claim was attributable to the claimant and did not establish good cause); *Roger Eli*, 47 Van Natta 1938 (1995) (the claimant's erroneous belief that claim would be covered by one of two carriers did not establish good cause where record did not indicate that either carrier misled the claimant). Consequently, in this case, we affirm the ALJ's decision to dismiss claimant's request for hearing for lack of jurisdiction.

ORDER

The ALJ's order dated October 29, 1998 is affirmed.

February 8, 1999 Cite as 51 Van Natta 227 (1999)

In the Matter of the Compensation of
GEORGE B. HUETH, Claimant
WCB Case No. 98-04521
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral hearing loss condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order. *See Brown v. A-Dec, Inc.*, 154 Or App 244 (1998); *Bailey v. Reynolds Metals*, 153 Or App 498 (1998); *John W. Wantowski*, 50 Van Natta 2027 (1998) (Hearing loss not compensable because major contributing cause was age-related presbycusis, not work exposure); *Jim M. Greene*, 47 Van Natta 2245 (1995) (Where the claimant did not first establish that he was prohibited from

bringing a civil action, there was no showing of injury by operation of ORS 656.018 and no violation of Article 1, section 10 of the Oregon Constitution).

ORDER

The ALJ's order dated September 23, 1998 is affirmed.

February 8, 1999 Cite as 51 Van Natta 228 (1999)

In the Matter of the Compensation of
JAMES V. COMPTON, Claimant
WCB Case No. C8-02692
THIRD ORDER DENYING RECONSIDERATION OF
CLAIM DISPOSITION AGREEMENT
Schneider, et al, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Member Biehl and Haynes.

The SAIF Corporation has requested reconsideration of our December 15, 1998 and January 7, 1999 orders denying reconsideration of the claim disposition agreement (CDA) approved on November 24, 1998. We deny the motion for reconsideration.

On November 24, 1998, we approved the parties' CDA. On December 8, 1998, more than 10 days after the CDA was approved, we received the parties' addendum to the CDA, which provided for reimbursement of $131,921.68 of the CDA proceeds by the Workers' Benefit Fund. The addendum contained the signature of the Director's representative. We treated the addendum as a motion for reconsideration of the approved CDA. On December 15, 1998, we denied reconsideration of the CDA because the motion for reconsideration was untimely filed under OAR 438-009-0035. *James V. Compton*, 50 Van Natta 2353 (1998).

On December 21, 1998, we received SAIF's motion for reconsideration of our order denying reconsideration of the CDA. After addressing SAIF's arguments, we again denied reconsideration. *James V. Compton*, 51 Van Natta 6 (1999).

On February 4, 1999, SAIF filed a second motion for reconsideration. In its motion, SAIF first argues that ORS 656.236(1)(a) requires that we approve the CDA addendum. ORS 656.236(1)(a) provides, in relevant part:

> " * * * The disposition shall be approved in a final order unless: (A) The board finds the proposed disposition is unreasonable as a matter of law; (B) The board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or (C) Within 30 days of submitting the disposition for approval, the worker, the insurer or self-insured employer requests the board to disapprove the disposition."

Consistent with ORS 656.236(1)(a), we found no statutory basis to disapprove the original CDA and we approved it in a final order on November 24, 1998. After the 10 day reconsideration period allowed under OAR 438-009-0035, SAIF filed the addendum, which we treated as a motion to reconsider the approved CDA. As we explained in our original order denying reconsideration, once the CDA is approved, it is final and is subject to no further review. *See* ORS 656.236(2). We do not have statutory authority to alter the previously approved CDA.[1]

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[1] To the extent that SAIF argues that the addendum is not a motion to reconsider the approved CDA, our response is the same. Even assuming, for the sake of argument, that the addendum should not be treated as a motion to reconsider the approved CDA, the original CDA which the addendum seeks to amend has been approved in a final order. Thus, we are still without authority to alter the already approved CDA. For the same reasons, we reject SAIF's argument that ORS 656.236(2) does not prevent parties from adding terms to the CDA at any time. Such an interpretation would be inconsistent with the statute in that no CDA would ever be final and would always be subject to amendment and/or revocation. SAIF asserts that the CDA may be altered until final, which does not occur for 30 days under ORS 656.295(8). We note that *approved* CDAs are *not* appealable to the court. Only CDAs that have been disapproved may be appealed. ORS 656.236(2).

SAIF next argues that the addendum qualifies as a stipulation and that the Board has separate authority to execute it. We disagree. The addendum submitted by SAIF alters a previously approved CDA. As explained herein, the statute does not allow an approved CDA to be altered. In addition, stipulations resolve "contested matters," (either arising out of a claim after an order on reconsideration where a hearing request has been filed, or for "non-claim closure" issues, at any time whether or not a hearing request has been filed). *See* OAR 438-009-0005(1),(2). The addendum does not resolve a "contested matter," certainly not one between claimant and SAIF. This conclusion is confirmed in SAIF's motion, which acknowledges that the "basic term of the addendum is to allow the reimbursement of a portion of the settlement proceeds from the Department of Consumer and Business Services." (Second Motion for Reconsideration, Page 2, lines 8-10).

In other words, as SAIF recognizes, this matter is a "reimbursement" question between SAIF and the Department of Consumer and Business Services. Matters of reimbursement are not "matters concerning a claim" over which the Board or Hearings Division has jurisdiction under ORS 656.704(3).[2] *See, e.g., Lloyd v. EBI*, 96 Or App 591 (1989) (reimbursement issue between insurer and paying agent was not a matter concerning a claim, where the worker had already received his compensation and was no longer a party to the dispute); *see also EBI v. Kemper Group*, 92 Or App 319 (1988).

SAIF argues that the Board's rule places an "artificial time limit" on agreements by the parties. On the contrary, parties have an unlimited time period to reach an agreement. The rule only places a time period for *reconsideration* after a CDA is approved.

SAIF next asserts that the language in the CDA in which SAIF reserves its rights and remedies under ORS 656.576 to 656.595 "allows for amendments to protect the rights of SAIF." ORS 656.576 to 656.595 pertain to "third party" recoveries. This CDA provision is apparently intended to confirm that SAIF retains its rights to share in any future recovery from a third party action (if there is a third party suit).[3] The provision has no effect on SAIF's rights to seek further amendment of previously approved CDAs or the Board's authority to approve an amendment of an approved CDA. Even if the language reserving third party rights could be interpreted as allowing the alteration of an approved CDA, we would not interpret the language in such a manner since it would be contrary ORS 656.236 which provides that CDAs are final and not reviewable after they are approved.

Finally, SAIF argues that the Board has authority to issue an order approving the reimbursement for the CDA proceeds from the Workers' Benefit Fund. SAIF argues that the Board prescribes the amounts for reimbursement from the Reopened Claims Program under ORS 656.625, which provides that " * * * any reimbursement from the Reopened Claims Program shall be in such amounts as the board prescribes and only to the extent that moneys are available in the fund as determined by the Director of the Department of Consumer and Business Services."

SAIF refers to ORS 656.625 which pertains to Board awards pursuant to its Own Motion authority under ORS 656.278. This matter pertains to a CDA, not an "Own Motion" order or award. In any case, even assuming that ORS 656.625 is applicable, the Board lacks jurisdiction to authorize such reimbursements. *See SAIF v. Holmstrom*, 113 Or App 242 (1992). Under the statutory scheme, that authority rests with the Director.

For the reasons expressed herein, as well as those expressed in our previous orders, we deny the motion for reconsideration.

IT IS SO ORDERED.

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[2] The Board's jurisdiction is limited to "matters concerning a claim" which are defined as those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

[3] We have held that, in the absence of an express waiver in the CDA of the carrier's lien rights under ORS 656.580 and 656.593, a CDA does not deprive the carrier of its statutory right to recovery from the third party proceeds. *See Benny H. Rash*, 49 Van Natta 2124 (1997).

In the Matter of the Compensation of
DIANE K. COTTER, Claimant
WCB Case Nos. 98-06092, 97-08791 & 98-04927
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that assessed a $4,000 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issues are remand and attorney fees.

We deny SAIF's request for remand, and adopt and affirm the ALJ's order with the following supplementation on the attorney fee issue.

Claimant requested a hearing challenging, among other things, SAIF's denial of her right carpal tunnel syndrome. Following the hearing, the ALJ ordered that SAIF, on behalf of employer Brian Jackson, accept claimant's current right carpal tunnel syndrome as part of claimant's 1993 claim for a right wrist injury. The ALJ also ordered SAIF to pay claimant's attorney an assessed fee of $4,000 for services in setting aside the denial.

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding the factors set forth in OAR 438-015-0010(4) where, as in this case, there is no specific attorney fee requested and the parties did not submit arguments addressing the factors to be weighed in determining a reasonable fee.[1] *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

Here, because the ALJ simply ordered SAIF to pay $4,000 and did not indicate the factors applied in determining the fee amount, we agree that the ALJ's reasoning is insufficient. Nevertheless, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), it is not necessary for us to remand the case to the ALJ for supplementation of findings on this issue. *See Daryl L. Underwood*, 50 Van Natta 2330.

As noted above, claimant's attorney did not submit a statement of services showing the time devoted to the case. The record establishes, however, that the hearing lasted approximately two hours and two witnesses, including claimant, testified on claimant's behalf. The transcript consists of 49 pages. Forty-seven exhibits were offered and admitted into evidence, including at least one medical report generated by claimant's attorney.

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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."

Based on compensability disputes generally litigated before this forum, we find the compensability issues involved in this case of average complexity. A preponderance of the evidence establishes that claimant's work activities since April 1990 were the major contributing cause of her right carpal tunnel syndrome, and also that her condition worsened sometime after July 1991, when she began working for Brian Jackson. Consequently, claimant's counsel obtained benefits for claimant's long-standing right carpal tunnel syndrome. Because the medical reports concerning the cause of claimant's right carpal tunnel syndrome were divided, however, there was a risk that claimant's attorney might go uncompensated. Finally, the attorneys involved in this case are skilled litigators with substantial experience in workers' compensation law.

Based on the factors discussed above, we agree with the ALJ that $4,000 is a reasonable fee for claimant's counsel's services at hearing.[2]

ORDER

The ALJ's order dated October 15, 1998 is affirmed.

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[2] Because SAIF challenged only the attorney fee award on review and 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 review. *See Dotson v. Bohemia*, 80 Or App 233 (1986).

February 8, 1999 Cite as 51 Van Natta 231 (1999)

In the Matter of the Compensation of
JEFFREY S. HODEL, Claimant
WCB Case No. 97-10042
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of claimant's claim for a back condition. On review, the issue is compensability.

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

The ALJ found that the medical opinions supporting compensability were unpersuasive since they lacked a history of claimant's preexisting condition. On review, claimant argues that the preexisting condition did not affect claimant's back and is irrelevant.

Claimant has a serious illness which causes chronic pain in multiple parts of his body. As the ALJ noted, claimant had back pain beginning on the first day he worked for the employer. Although it is unclear whether claimant's preexisting illness affected the back, the fact that the physicians treating claimant apparently did not know of the serious disease and the pain problems it caused persuades us that the information may have been relevant to the cause of claimant's back pain. Under such circumstances, we agree with the ALJ that the lack of an accurate history of the preexisting condition renders the medical opinions unpersuasive.

ORDER

The ALJ's order dated October 5, 1998 is affirmed.

In the Matter of the Compensation of
JASON K. ARCENEAUX, Claimant
WCB Case No. 98-03877
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that assessed a $3,000 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 found claimant's low back condition compensable and awarded an assessed attorney fee of $3,000, without mentioning or discussing the factors in OAR 438-015-0010(4).[1]

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)."

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.

Here, as in *Underwood*, SAIF did not (and continues not to) provide any discussion or argument concerning the application of the rule-based factors. Nevertheless, in light of the Court's discussion in *McCarthy*, the award of a reasonable attorney fee requires "a brief description or citation to the factor or factors" relied on in arriving at such a fee. Although the ALJ's order contains no such citation or discussion, unlike the courts' review authority, our review is *de novo* based on the entire record. Because we may modify or supplement the ALJ's order on review, and because we do not find the record to be improperly, incompletely, or otherwise insufficiently developed, we deny SAIF's motion for remand. *Daryl L. Underwood*, 50 Van Natta at 2332.

Finally, we provide the following reasoning on *de novo* review. With regard to the time factor, we note that the hearing lasted an hour and that three witnesses testified, including claimant. The record is made up of approximately 18 exhibits, including at least one medical report generated and submitted by claimant's attorney.

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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.

We find the issues to be of average complexity. The value of the interest involved and the benefit secured for claimant were within the range of those generally considered by the Hearings Division. Because the medical reports concerning causation were divided, there was a risk claimant's attorney would go uncompensated. Finally, both attorneys presented their cases in a skillful manner.

Based on these factors, we agree with the ALJ that $3,000 is a reasonable attorney fee. 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 November 9, 1998 is affirmed.

February 9, 1999 Cite as 51 Van Natta 233 (1999)

In the Matter of the Compensation of
JANIS R. DAVIS, Claimant
WCB Case No. 98-04128
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a cervical injury, whereas an Order on Reconsideration awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant, age 32, works for the employer as a cashier. On January 2, 1997, she slipped and fell on a patch of ice in the employer's parking lot and injured her neck. She was diagnosed with a cervical strain and prescribed physical therapy and medication. Due to the injury, claimant was off work from January 3, 1997 to January 16, 1997. On January 17, 1997, claimant was released for, and returned to, light duty work.

Claimant's symptoms persisted and she continued treating with Dr. Fisher. On September 13, 1997, claimant underwent a physical capacities evaluation (PCE). The occupational therapist reported, among other things, that claimant could frequently lift 10 pounds and occasionally lift 15 pounds. Dr. Fisher agreed with the PCE report, noting that claimant could work within the limits of her demonstrated abilities and that the stated restrictions "should remain in effect indefinitely."

On October 24, 1997, claimant was evaluated by Drs. Rich and Marble at the employer's request. Drs. Rich and Marble noted that although claimant had a congenital blocked vertebrae in the cervical spine, it was "of no consequence." They also reported that, "[a]bsent a preexisting condition, any impairment found today would relate to the January 2, 1997 slip and fall injury." In concluding that claimant was medically stationary, however, the doctors noted that they "found no evidence to suggest permanent impairment." Dr. Fisher concurred with the findings and report of Drs. Rich and Marble.

The claim was closed by a Notice of Closure issued February 6, 1998, which awarded no permanent disability. Claimant requested reconsideration.

A May 19, 1998 Order on Reconsideration affirmed the Notice of Closure. On May 29, 1998, claimant was evaluated by a medical arbiter panel consisting of Drs. Yerby, Bald and Schilperoort. The

arbiter panel found reduced range of motion of the cervical spine,[1] but found that claimant's range of motion *in extension* was affected by her congenital abnormality. The panel reported that, because of the abnormality, claimant's range of motion in extension was approximately 50 percent of normal. The panel concluded that their examination was valid and that the percentage of impairment in extension due to the accepted cervical strain was 1 percent. The panel also found that claimant's accepted strain resulted in no restrictions in the number of hours she could work or in her ability to perform the functions of her job.

CONCLUSIONS OF LAW AND OPINION

Based on the arbiter's range of motion findings, the ALJ concluded that claimant was entitled to an award of 4 percent impairment under OAR 436-035-0360(13)-(16). The ALJ also found, based on Dr. Fisher's work release and the PCE, that claimant was entitled to a value of 6 for social/vocational and adaptability factors for a total unscheduled permanent disability award of 10 percent.

On review, the employer argues that claimant has not established any permanent cervical impairment due to her accepted cervical strain, because Drs. Rich and Marble indicated they did not expect claimant's loss of motion to be permanent. The employer also challenges the ALJ's determination that claimant is entitled to a value for social/vocational and adaptability factors, because the arbiter panel concluded claimant was able to perform the functions of her regular work as a cashier.

For the reasons that follow, we conclude claimant is entitled to an award of 7 percent unscheduled permanent disability.

Evaluation of a worker's disability is as of the date of issuance of the reconsideration order. ORS 656.283(7). When rating impairment, we may consider only the opinions of the attending physician (or the findings and opinions with which he or she has concurred) and the medical arbiter, if any. *See Roseburg Forest Products v. Owen*, 129 Or App 442 (1994); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Where a medical arbiter is used, as in this case, we do not automatically defer to the medical arbiter's opinion in evaluating impairment, but rather, rely on the most thorough, complete, and well-reasoned evaluation of impairment due to the injury. *See David L. Glenn*, 49 Van Natta 1251 (1997); *Kenneth W. Matlack*, 46 Van Natta 1631 (1994); *Carlos S. Cobian*, 45 Van Natta 1582 (1993).

Here, after considering the findings ratified by Dr. Fisher and those of the medical arbiter panel, we find that the medical arbiter panel provided the most reliable evaluation of claimant's injury-related impairment as of the date of issuance of the Order on Reconsideration. First, the medical arbiter panel examination was conducted much closer in time to the May 1, 1998 Order on Reconsideration than the October 24, 1997 examination by Drs. Rich and Marble. Second, like the ALJ, we find the report of Drs. Rich and Marble (with which Dr. Fisher concurred) to be inherently inconsistent. On the one hand, the doctors reported that claimant was medically stationary and attributed any impairment found to the accepted injury.[2] On the other hand, the doctors also noted that they found no evidence to suggest permanent impairment. Because this apparent inconsistency is unexplained, we find the report unpersuasive.[3] We therefore rely on the medical arbiters' findings of claimant's injury-related impairment and conclude that claimant is entitled to an impairment award of 4 percent under OAR 436-035-0360(13)-(16) (WCD Admin. Order 96-072) for lost range of motion of the cervical spine due to the accepted injury.[4]

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[1] The panel reported the following ranges of motion of claimant's cervical spine: Cervical flexion, 46 degrees; cervical extension, 28 degrees; right lateral flexion, 32 degrees; left lateral flexion 40 degrees; right rotation 82 degrees and left rotation 80 degrees. (Ex. 37-2).

[2] Drs. Rich and Marble found, among other things, a measurable loss of cervical flexion and extension.

[3] Indeed, although Drs. Rich and Marble found no evidence to suggest permanent impairment when they declared claimant medically stationary in October 1997, the medical arbiter panel found similar impairment (loss of cervical range of motion) seven months later. The medical arbiters' findings therefore belie the assumption of Drs. Rich and Marble that claimant's impairment would not be permanent.

[4] This award consists of a value of 1.4 percent for loss of cervical flexion, .87 percent for loss of right lateral flexion, .33 percent for loss of left lateral flexion and 1 percent for loss of exension. (1.4 + .87 + .33 + 1 = 3.70, rounded up to 4 percent).

With regard to claimant's adaptability, the medical arbiter panel concluded that claimant had no lifting or carrying limitations based on the accepted condition and no limitation in the number of hours she is able to work. Along the same line, Dr. Fisher ratified the opinion of Drs. Rich and Marble that claimant could gradually resume her regular job activities.[5] Based on this evidence, we are persuaded that claimant's residual functional capacity (RFC) is the same as her base functional capacity (BFC), and therefore claimant is entitled to an adaptability value of 1. *See* OAR 436-035-0270(4); OAR 436-035-0310.

Assembling the factors under the applicable standards, claimant is entitled to a total award of 7 percent unscheduled permanent disability, consisting of a value of 3 for education multiplied by +1 for adaptability added to the impairment value of 4. *See* OAR 436-035-0280.

ORDER

The ALJ's order dated October 15, 1998, as amended on October 27, 1998, is modified. In lieu of the ALJ's award of 10 percent unscheduled permanent disability, claimant is awarded 7 percent unscheduled permanent disability for her cervical injury. Claimant's counsel's "out-of-compensation" attorney fee is modified accordingly.

[5] Although Dr. Fisher agreed that claimant could eventually resume her regular job activities, we find no persuasive evidence in the record that Dr. Fisher released claimant to unrestricted work or that claimant actually returned to regular, unrestricted work. Therefore, we decline to apply ORS 656.726(3)(f)(D) and do not limit our evaluation of claimant's disability to her impairment only.

In the Matter of the Compensation of
TOD DEITZ, Claimant
WCB Case No. 97-05437
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James F. Evans, Attorney
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's claim for injuries sustained in a motor vehicle accident. On review, the issues are course and scope of employment and compensability. We reverse.

FINDINGS OF FACT

Claimant, age 24 at the time of hearing, worked as a laborer for the employer, a metal rain gutter and construction company. The employer's shop and business office is located in Turner, Oregon, at the home of the employer's owner, Mr. Howard. During this time, claimant lived in Salem.

On most work days, claimant would meet his co-workers at the employer's shop in Turner, help load the necessary tools and materials into a company-owned vehicle, and ride to the job site in a company vehicle. Then, at the end of the day, claimant would ride back to the employer's premises and help unload the company vehicle before heading home. On some days, however, if claimant knew the location of the job site ahead of time, he would drive directly to the job site from his home. On the days where claimant met his co-workers at the employer's shop and drove to the job site in a company-owned gutter truck, he was paid from the time he arrived at the shop until he left the job site at the end of the day. But, when he drove on his own to the job site, he was not paid for travel time.

In March 1997, claimant was working on a long-term construction project in Aurora. The employer was a subcontractor, and claimant's job was to assist in the construction of a pole barn. During this time, claimant's car was in the body shop, so he was getting rides to and from work with a co-worker, Mr. Mowdy.

On March 20, 1997, Mr. Mowdy picked claimant up at home and the two drove to the employer's office in Turner. Rather than taking the employer's gutter truck (which was not necessary for the Aurora job) or Mr. Mowdy's truck (which was loaded up with garbage to be taken to the dump), Mr. Mowdy and claimant drove to the Aurora job site in a truck owned by Mr. Howard personally.[1] At the end of the work day, Mr. Mowdy and claimant boarded the same truck to go home.

As Mr. Mowdy and claimant were heading home,[2] Mr. Mowdy rear-ended another vehicle on I-5 south, near Woodburn. The collision caused the truck's bench seat to slide forward, and claimant's knee struck the dashboard. After the accident, claimant experienced pain in his knee and upper back, although he did not seek immediate medical attention.

Claimant terminated his employment approximately three weeks after the accident, in mid-April 1997. About two weeks later, on April 28, 1997, he commenced chiropractic treatment for back and knee pain.

On May 29, 1997, claimant was seen by Dr. Jura. Dr. Jura reported abnormal range of motion of the cervical and dorsolumbar spine and of the left knee.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was compensably injured within the course and scope of his employment under the "employer's conveyance" exception to the "going and coming rule." On review, the insurer disputes the ALJ's finding that claimant and Mr. Mowdy were heading back to the employer's premises and were in the employer's conveyance at the time of the accident. We agree with the insurer.

Ordinarily, an injury sustained while a worker is going to or coming from work is not considered to have occurred "in the course of" employment and, therefore, is not compensable. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526 (1996) (citing *Cope v. West American Ins. Co.*, 309 Or 232, 237 (1990)); *Philpott v. State Ind. Acc. Com.*, 234 Or 37, 40 (1963). The reason for this rule is that the relationship of employer and worker is usually suspended from the time the worker leaves work to go home until he or she resumes work because, while going to or coming from work, the worker is rendering no service for the employer. *See Krushwitz*, 323 Or at 526-27 (citing *Heide v. T.C.I. Incorporated*, 264 Or 535, 540 (1973)).

There are, however, some exceptions to the "going and coming" rule. One is the "employer's conveyance" exception. Under this exception, injuries sustained while the worker is traveling to or from a work site in a vehicle under the control of the employer have been found compensable. As Larson explains:

> "When the journey to or from work is made in the employer's conveyance, the journey is in the course of employment, the reason being that the risks of the employment continue throughout the journey." 1 Larson, Workmen's Compensation Law 4-209, Sec. 17.00 (1994).
>
> "If the trip to and from work is made in a truck, bus, car, or other vehicle under the control of the employer, an injury during that trip is incurred in the course of employment." 1 Larson, at 4-209, Sec. 17.11; *Giltner v. Commodore Con. Carriers*, 14 Or App 340 (1972).

We applied the "employer's conveyance" exception in *Chris L. Sargent*, 47 Van Natta 959 (1995). There, the claimant, a roofer, was injured in a motor vehicle accident that occurred while he was receiving a ride with the employer from the employer's premises to a job site location known only by the employer. We held that providing the ride from the business office to the job site expanded the

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[1] Although Mr. Howard authorized Mr. Mowdy to drive this truck to the job site that day, the employer did not own the truck nor pay for it in any way. It was one of Mr. Howard's personal vehicles. Furthermore, unlike the company-owned vehicles, this truck did not have the company's logo painted on it.

[2] Claimant testified that he and Mr. Mowdy were headed "back to Salem" and "back to my own house" rather than to the employer's shop in Turner. (Tr. at 14-15). Claimant also explained that there were not many tools in this truck, so he did not have to help unload them. *Id.*

range of risks assumed by the employer and was under the employer's control, such that the claimant was injured within the course of employment. We also explained that because the employer expected his employees to gather at his business premises, eat breakfast together and continue on to the job location which was known only to him, the risk that the claimant would be injured while traveling to the job site was a risk of employment. 47 Van Natta at 960.

Similarly, in *Roy J. Johnson*, 46 Van Natta 1117 (1994), we found the claimant's injuries compensable when he was injured in a motor vehicle accident on his way back to the employer's premises. In that case, the claimant, also a roofer, worked for an employer who preferred that employees go directly to the job site on a "roofing" project. Because the claimant did not have a driver's license, he relied on his wife and/or co-workers for transportation to and from work. On the day of injury, the claimant rode to the job site with a co-worker. At the end of the day, he asked one of the foreman for a ride to the shop, because the shop was closer to his home than the job site. As the two were returning to the employer's shop in the company's truck, they were rear-ended by another vehicle. Under these circumstances, we found that, because the foreman was required to return to the shop and the claimant was expected to (and had intended to) help unload the truck upon arrival, the claimant was within the course of employment at the time of the injury. We found that, in essence, the claimant was injured while "traveling between two portions of the employer's premises," the roofing job site and the employer's shop, where he unloaded materials. We therefore concluded that the travel to the employer's shop was part of the service performed for the employer even though the claimant was not paid for this time.

Although the ALJ found *Roy Johnson* similar to the case at hand, we find significant distinctions. First, considering claimant's testimony that he and Mr. Mowdy were headed "back to Salem" (rather than the employer's shop in Turner) and that he had no plans to help unload the truck, we find that claimant was not "traveling between two portions of the employer's premises" when he was injured. Second, unlike *Roy Johnson*, claimant was not riding in a company-owned vehicle with a supervisor who was paid for his travel and required to return to the shop.[3]

We acknowledge that Mr. Howard gave Mr. Mowdy permission to drive his truck to the Aurora job site and that this truck had occasionally been pressed into service for the employer in the past, but we find these facts insufficient to bring claimant's injury within the "employer conveyance" exception to the "going and coming" rule. The evidence establishes that, at the time of the accident, Mr. Mowdy was driving claimant home and that claimant had no intention of unloading the truck or performing any further services for the employer's benefit that day. Consequently, we find that claimant's injury did not occur in the course of his employment.

ORDER

The ALJ's order dated May 29, 1998, as reconsidered September 22, 1998, is reversed. The insurer's May 13, 1997 denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

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[3] Although it makes logical sense that Mr. Mowdy would, at some point, go back to the employer's premises so that he could return Mr. Howard's truck and drive his own vehicle home, there is no evidence on this issue in the record. Thus, we cannot presume that Mr. Mowdy was obligated to return to the employer's shop and unload whatever tools may have been in the truck on the day of the accident.

In the Matter of the Compensation of
JORGE GARFIAS-LARA, Claimant
WCB Case Nos. 97-02664 & 96-11236
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's injury claim for low back disc herniations/bulges. On review, the issue is compensability.

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

The ALJ set aside the insurer's denial of L4-5 and L5-S1 disc conditions. In doing so, the ALJ concluded that claimant had sustained his burden of proving that his compensable March 12, 1996 low back injury, which was accepted as a lumbosacral strain, was a material contributing cause of his need for disability or medical treatment for the disc conditions. In reaching this conclusion, the ALJ found the medical opinions of two physicians who supported compensability, Dr. Rodriguez, an attending physician, and Dr. Gritzka, who reviewed medical records on claimant's behalf, more persuasive than the contrary opinion of an examining physician, Dr. Rosenbaum.

On review, the insurer first contends that the ALJ should have applied the major contributing cause standard of ORS 656.005(7)(a)(B). The insurer then asserts that we should find Dr. Rosenbaum's opinion most persuasive and conclude that claimant failed to sustain his burden of proof. We disagree with the insurer's arguments.

For the major contributing cause standard of ORS 656.005(7)(a)(B) to apply, a preexisting condition must have "combined" with the compensable injury to cause disability or need for treatment. *Richard L. Ulmen*, 50 Van Natta 1033, 1034 (1998). We conclude that the evidence here does not establish a "combined" condition. In fact, Dr. Rosenbaum, the physician on whom the insurer primarily relies, specifically stated that claimant's preexisting degenerative disc disease did not combine with the compensable injury. (Ex. 35-5).

Accordingly, we find that ORS 656.005(7)(a)(B) is inapplicable. Therefore, we conclude that the ALJ properly applied a material contributing cause standard. *Kevin R. Ritchey*, 48 Van Natta 1847 (1996). Moreover, we agree for the reasons the ALJ cited that claimant sustained his burden of proof under that standard.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 October 13, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
MAGGIE L. GIBSON, Claimant
WCB Case No. 98-02262
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that awarded an assessed attorney fee of $3,000. In her brief, claimant moves to dismiss SAIF's request for review. On review, the issues are dismissal and attorney fees. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ issued an order finding that claimant proved compensability. The ALJ also ordered SAIF to "pay to claimant's counsel $3,000 as and for a reasonable carrier-paid fee for her efforts in this matter."

SAIF requested review of only that portion of the order awarding an attorney fee, arguing that the ALJ failed to apply each of the factors in OAR 438-015-0010(4) and make specific findings of fact for each factor. SAIF requests that the Board "apply the factors to determine an appropriate attorney fee." Alternatively, SAIF asks that the case be remanded if "more information is needed." In her brief, claimant moves to dismiss SAIF's request for review because SAIF did not argue the attorney fee issue at hearing. Claimant also asserts that the Board may make its own rule-based findings and that the ALJ's attorney fee award is reasonable.

We first deny the motion to dismiss. There is no contention that SAIF did not timely file its request for review or that its appeal is otherwise faulty. Consequently, the Board has jurisdiction to consider the request for review.

Rather than asserting a problem with jurisdiction, claimant appears to contend that we should not address the attorney fee issue because it was not raised at hearing. As we explained in *Phyllis M. Hays*, 50 Van Natta 696, *on recon* 50 Van Natta 867 (1998), we treat such an issue as an exception to our general rule that a party must "preserve" an issue at hearing in order to challenge it on review. We do so on the basis that the attorney fee award is a "natural derivative" of the compensability issue decided at hearing. Thus, in this case, we conclude that SAIF can challenge the attorney fee award on review. We now turn to the merits.

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. Instead, 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. *See McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998); *Turnbow v. K.E. Enterprises, Inc.*, 155 Or App 59 (1998) (finding that, pursuant to *McCarthy*, the absence of explanatory findings to support an award or a denial of attorney fees is not a ground for reversal and a court need only address the objections under the statute that are material to its decision).

Here, however, the ALJ simply ordered SAIF to pay "claimant's counsel $3,000 as and for a reasonable carrier-paid fee for her efforts in this matter." 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. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). Nevertheless, because we are authorized to modify or supplement the ALJ's findings and conclusions under ORS 656.295(6), we proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing. *Id.* at 2332. Thus, it is not necessary to remand the case to the ALJ.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The primary issue at hearing was compensability of claimant's occupational claim for a right shoulder condition. Although claimant did not provide a written statement of services at hearing, on review she submits her counsel's statement documenting 14.5 hours spent on the case. The hearing lasted approximately one and one-half hours. Only claimant testified. The record contains 24 exhibits, at least two of which were generated by claimant's attorney. There were no depositions.

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. Because claimant's right shoulder 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, based on the existence of a preexisting condition, there was a risk that claimant's counsel's efforts might have gone uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing is $3,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.[1]

ORDER

The ALJ's order dated August 24, 1998 is affirmed.

[1] Claimant is not entitled to an attorney fee for her counsel's services on Board review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

February 9, 1999 Cite as 51 Van Natta 240 (1999)

In the Matter of the Compensation of
THOMAS J. KAMINSKI, Claimant
WCB Case No. 96-08558
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Emmons, Kropp, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the self-insured employer's denial of claimant claim for a current L5 nerve root compression condition. On review, the issue is aggravation.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 11, 1998 is affirmed.

Board Member Biehl dissenting.

Claimant had three compensable low back injuries --in 1974, 1988, and 1993 -- and two related (compensable) surgeries. Then, after claimant's low back condition worsened in 1996, Dr. Golden performed a bilateral decompression laminectomy from L4 to S1 in 1997. Based primarily on his surgical findings, Dr. Golden opined that scarring due to the 1993 compensable surgery was the major contributing cause of claimant's need for surgery in 1997.

The employer denied claimant's 1996 aggravation claim on causation grounds.

The majority upholds the denial based on the opinions of claimant's "one-time" examiners, Drs. Thomas and Richard Rosenbaum. The majority reasons that Dr. Golden's opinion supporting the claim is "implausible," inadequately explained, and based on an inaccurate understanding of responsibility law as well as an inaccurate and incomplete history.

I agree with the majority that *Dr. Golden's* opinion establishes that pressure on claimant's L5 nerve root caused his 1996 need for surgery and that claimant's current condition results from a combination of age-related degenerative foraminal stenosis, bilateral scar tissue due to previous surgery, and claimant's work activities after the 1993 surgery. I also agree with the majority that the "relevant question is whether the compensable 1993 injury was the major contributing cause of the scar tissue at L4-5 bilaterally and whether [] that scar tissue is the major contributing cause of the L5 nerve root compression requiring the surgery." Opinion and Order, p. 4.

But I disagree with the majority's legal reasoning and its characterization of the record, especially Dr. Golden's opinion.

First, Dr. Golden's opinion regarding legal responsibility should not influence evaluation of the medical evidence because it is simply not relevant to the medical question. To the extent that the majority discounts Dr. Golden's opinion because he mistakenly believed that the contribution from claimant's work activities after 1993 (under different coverage) are this employer's responsibility, its reasoning is unpersuasive. Moreover, and more importantly, to the extent that claimant's post-1993 work activities contributed to his 1997 need for low back surgery, those activities would be *compensable* contributors.

Second, contrary to the majority's finding, the record indicates that Dr. Golden had a materially accurate history regarding claimant's 1974 L4-5 surgery: He was aware of the nature and location of claimant's 1974 low back condition and surgery. (Ex. 123-5; *see* Exs. 4, 5, 9, 11; *see also* Ex. 123-25). There is no evidence that Dr. Golden lacked material information about the 1974 procedure or about claimant's history generally.[1] In fact, Dr. Golden was in a particularly good position to evaluate claimant's low back condition, because he performed the 1993 and 1997 surgeries.

Dr. Golden's opinion is also well-reasoned and consistent with claimant's history. He observed and recorded right-sided, as well as left-sided findings associated with claimant's worsened 1996 condition.[2] Moreover, and more importantly, Dr. Golden explained why claimant's primarily left-sided symptoms were *not inconsistent* with the primarily right-sided pathology identified at surgery. (Ex. 123-15-18; -24-25). In other words, Dr. Golden explained why the exact location of claimant's symptoms and pathology (*i.e.*, right v. left) is *not* medically significant. What *is* significant is that the 1993 surgery caused scarring, and that scarring and related progressive degeneration caused claimant's need for treatment in 1997. Dr. Golden clearly explained that claimant's low back surgeries, particularly the 1993 procedure, worsened his preexisting stenosis by accelerating its degeneration *and*, significantly, by causing additional narrowing of the spinal canal due to surgery-related scar tissue. (Exs. 123-9-12; 123-35-43, 123-46-47). In other words, Dr. Golden clearly explained how claimant's right-sided 1993 surgery could and did cause bilateral scar tissue. He also considered and weighed or ruled out potential noncompensable contributing causes in reaching his conclusion that the 1993 injury was the major contributing cause of claimant's most recent need for low back surgery. (*See* Exs. 123-12-13; 123-42).

The majority relies on the examiners' opinions that left-sided problems could not result from right-sided surgery. But claimant's treating surgeon explained how that *did* happen in claimant's case and he observed claimant's condition firsthand, *twice* --before and after the worsening in question. The examiners could only speculate that what happened to claimant was "unlikely." They could not refute Dr. Golden's surgical observations or otherwise rebut his reasoning. Under these circumstances, I believe the majority errs in substituting its medical judgment for essentially unrefuted medical evidence.

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[1] I would also note that *all* claimant's low back injuries are compensable and therefore none of them constitute a preexisting condition that weigh against the current claim. *See Pepsi-Cola Bottling Co. v. Walton*, 147 Or App 698, 703 (1997) (Conditions previously determined to be compensable are not "preexisting conditions" under ORS 656.005(7)(a)(B)).

[2] These findings included "ankle jerks" absent bilaterally and bilateral foot weakness. (*See* Exs. 101, 108, 113-1, 116).

Dr. Golden had the particular advantage of viewing claimant's low back condition firsthand in 1993 and 1996 and his reasoning and conclusions are based primarily on his surgical findings. (*See* Ex. 123-14). *See Argonaut Insurance Company v. Mageske*, 93 Or App 698 (1988). Based on his opinion, I would find claimant's aggravation claim compensable.

February 9, 1999 Cite as 51 Van Natta 242 (1999)

In the Matter of the Compensation of
ROBERT A. MOON, Claimant
WCB Case No. 98-05040
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that increased claimant's scheduled permanent disability award for the loss of use or function of the right leg (knee) from 5 percent (7.5 degrees), as awarded by an Order on Reconsideration, to 15 percent (22.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant compensably injured his right knee in December 1995 when he fell from a ladder at work. He sought treatment and was diagnosed with cellulitis and bursitis. SAIF accepted cellulitis secondary to abrasion of the right knee and chronic prepatellar bursitis of the right knee.

Claimant's claim was closed by a March 5, 1998 Notice of Closure which awarded no permanent disability. Claimant requested reconsideration and appointment of a medical arbiter. On May 15, 1998, claimant was examined by a medical arbiter panel (Drs. Woodward, Schilperoort and Braun), who found, among other things, a mild loss of flexion in the right knee and Grade 1 mild medial instability to valgus stress due to Grade 1 laxity of the medial collateral ligament of the right knee.

A June 8, 1998 Order on Reconsideration awarded claimant 5 percent scheduled permanent disability for loss of use of his right knee due to the mild loss of flexion, but declined to award disability benefits for the Grade 1 laxity. The Appellate Review Unit found that a preponderance of evidence failed to show that claimant suffered an injury to the ligaments as a result of the accepted condition and noted that the carrier had not accepted a medial collateral ligament injury. Claimant requested a hearing, seeking an additional 10 percent scheduled permanent disability for loss of use of the right knee, based on the Grade 1 laxity.

CONCLUSIONS OF LAW AND OPINION

Citing *SAIF v. Danboise*, 147 Or App 550, *rev den* 325 Or 438 (1997), the ALJ concluded that claimant's Grade 1 laxity was ratable under ORS 656.214(5) because the medical arbiters' report contained impairment findings that were consistent with claimant's right knee injury and the panel did not attribute those findings to causes other than the compensable injury. In *Danboise*, the court held that when a treating doctor or medical arbiter makes impairment findings and describes those findings as consistent with a claimant's compensable injury, and the medical record 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. 147 Or App at 553.

On review, SAIF contends that *Danboise* is inapplicable and that claimant's Grade 1 laxity is not ratable. Specifically, relying on cases such as *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), and *Donald D. Davis*, 50 Van Natta 357 (1998), SAIF argues that, in the absence of an accepted medial collateral ligament injury or evidence that this condition is a direct medical sequelae of the accepted conditions, claimant's laxity is not ratable. We agree with SAIF, for the reasons set forth below.

In *Garcia-Caro*, we held that the *accepted* condition determined what is included in rating permanent disability of a claim.[1] In that case, the accepted condition was right shoulder tendinitis. We found that, even though the medical evidence established that the claimant suffered a loss of range of motion of the cervical spine, that cervical impairment could not be included in the claimant's permanent disability award unless the carrier had accepted a cervical condition or the record established that the impairment was a direct medical sequelae of the accepted condition.[2] 50 Van Natta at 163.

Similarly, in *Davis*, the claimant had an accepted claim for "left elbow contusion." An Order on Reconsideration awarded permanent disability for an epicondylitis condition, which the Appellate Review Unit determined was a sequela of the accepted condition. We found that although the medical evidence showed that the claimant's epicondylitis condition was a sequela of the accidental injury, that condition was not a "direct medical sequela" of the accepted condition of left elbow contusion. Consequently, the claimant was not entitled to impairment for the epicondylitis condition under ORS 656.268(16).

In this case, as SAIF notes, the accepted conditions are cellulitis secondary to right knee abrasion and chronic prepatellar bursitis of the right knee. SAIF has not accepted (nor does the record reflect that claimant has requested that SAIF accept) any condition involving the medial collateral ligament. Therefore, claimant's Grade 1 laxity is not currently ratable unless claimant can establish that the unaccepted ligament condition is a direct medical sequela of one of the accepted conditions. *See Davis*, 50 Van Natta at 357; *see also Donald A. Westlake*, 50 Van Natta 1213 (1998) (where the medical evidence failed to show that the claimant's distal clavicle condition was accepted or that it constituted direct medical sequelae to the accepted condition of acute impingement syndrome, the claimant was not entitled to a permanent disability award based on the distal clavicle resection).

Although the medical arbiter panel found mild medial instability to valgus stress of the right knee due to Grade 1 laxity of the medial collateral ligament, the arbiters did not indicate that this impairment was a direct medical sequelae of the accepted cellulitis or bursitis. In the absence of such evidence, claimant is not entitled to a scheduled permanent disability award for his Grade 1 laxity of the medial collateral ligament. In order for claimant to be entitled to permanent disability for injury to his medial collateral ligament, it would be necessary for him to make a claim for that condition (*see* ORS 656.262(6)(d) and (7)(a)), and for the condition to be found compensable and the claim reopened (under ORS 656.262(7)(c)).

We acknowledge that, under *SAIF v. Danboise*, we may conclude that certain impairment findings are due to the compensable injury where the medical arbiter rates impairment and describes it as "consistent with" the compensable injury and the record discloses no other possible source of impairment. Nevertheless, in cases such as this, where the medical evidence does not address whether the impairment is consistent with, or does not indicate that the impairment is a direct medical sequelae of, an accepted condition, claimant has not sustained his burden of proof.[3] *See David D. Couture*, 50 Van Natta 1181 (1998) (finding that, in the absence of any evidence that loss of cervical range of motion is consistent with a low back injury, *Danboise* is inapplicable).

ORDER

The ALJ's order dated September 30, 1998 is reversed. The Order on Reconsideration's award of 5 percent (7.5 degrees) scheduled permanent disability for the right leg (knee) is reinstated and affirmed.

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[1] We explained that the term "accepted" is not the equivalent of "compensable." Although a compensable claim may also be an accepted claim, that is not always the case. 50 Van Natta at 161.

[2] ORS 656.268(16) requires that conditions that are "direct medical sequelae to the original accepted condition" be included in rating permanent disability of the claim unless they have been specifically denied.

[3] Because we are not an agency with specialized medical expertise entitled to take official notice of technical facts within our specialized knowledge, we must have medical evidence that the impairment is consistent with, or a direct sequelae of, the accepted condition. *See, e.g., SAIF v. Calder*, 157 Or App 224 (1998).

In the Matter of the Compensation of
NORMA J. NELSON, Claimant
WCB Case No. 97-09058
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of her bilateral carpal tunnel syndrome. On review, the issue is compensability. We affirm.[1]

FINDINGS OF FACT

Claimant has worked for the employer as an instructional assistant for a kindergarten class since November 1993. (Ex. 10). She works from September to June, 6 hours per day. (Tr. 8). She previously worked 5.6 hours per day in 1997. (Tr. 14; Ex. 10). Claimant performs a variety of job duties, including cutting construction paper, folding paper, stapling and operating a paper punch. (Ex. 10A, Tr. 8, 29). She also performs breakfast duty for 30 minutes each day. (Tr. 23). Claimant is right-handed. (Tr. 12).

On May 2, 1997, Dr. Loganbill reported that claimant had complained of numbness in her left hand that started about two weeks ago. (Ex. 3). She diagnosed left hand numbness, possible carpal tunnel syndrome (CTS). (*Id.*) Nerve conduction studies showed bilateral CTS, moderate on the left and mild on the right. (Exs. 5, 6). Claimant was referred to Dr. Collada. (Ex. 6).

On June 3, 1997, claimant was examined by Dr. Collada. (Ex. 8). He reported that claimant was having symptoms in both hands. (Ex. 8-1). Dr. Collada noted that claimant worked for the employer, but he did not refer to any of her job activities. (*Id.*) He agreed that claimant had bilateral CTS and recommended surgery, left side first. (Ex. 8-2). Dr. Collada performed a right carpal tunnel release on July 14, 1997. (Ex. 9).

On October 17, 1997, SAIF denied the claim on the basis that claimant's "injury" was not the major cause of her need for treatment and disability. (Ex. 14). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ was not persuaded by Dr. Collada's opinion on causation and she concluded that the claim was not compensable.

Claimant argues that her bilateral CTS claim is compensable either as an injury or an occupational disease. She relies on the opinion of her treating physician, Dr. Collada.

We need not determine whether claimant's claim should be analyzed as an injury or an occupational disease because we find that the claim fails under either theory. For the following reasons, we conclude that claimant has failed to prove that her bilateral CTS is compensable.

In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, Dr. Collada had examined claimant on one occasion before performing right carpal tunnel surgery. Under these circumstances, we do not grant any particular deference to Dr. Collada's opinion.

Furthermore, we are not persuaded by Dr. Collada's opinion because it is not well-reasoned and lacks adequate explanation. Dr. Collada's initial chart note indicated that claimant worked for the employer, but he did not refer to her job title or any of her job activities. (Ex. 8-1). On September 26, 1997, Dr. Collada wrote to SAIF, stating that he did not have a history of work activities that involved strenuous or repeated use of claimant's hands and he could not implicate her work as a cause of the

[1] We modify the ALJ's order to note that Exhibits 10A and 10B were also admitted in evidence.

CTS. (Ex. 13-1). He felt claimant's previous left hand sprain and weight gain may be contributing factors. (*Id.*) Dr. Collada was unable to determine the major contributing cause of claimant's bilateral CTS. (*Id.*)

On June 4, 1998, Dr. Collada wrote to claimant's attorney that, after reviewing some additional materials, "[i]t was very conceivable, based on all the information provided, that the activities [claimant] did while she worked in the kindergarten environment could have contributed" to her bilateral CTS. (Ex. 15). He noted, however, that claimant never mentioned her activities to him. (*Id.*) He said that "if the work activity she can strongly relate to symptoms, then I would have little way of disputing it." (*Id.*) Dr. Collada explained:

> "I certainly think the fact that she had it in both hands would make me apprehensive about saying it is the major contributing cause, but it is clear that [claimant] was mostly symptomatic in the hand that she was using mostly at work.
>
> "With the investigation you have mentioned in mind, and with the fact that [claimant] states now more conclusively that she relates it to her work activity, then I would certainly give support to stating that work was most likely the major contributing cause for her carpal tunnel syndrome. Again, I would have difficulty with the bilaterality for the reasons I mentioned." (*Id.*)

Claimant argues that Dr. Collada's opinion is based on an accurate history of her work activities, which she asserts was provided by SAIF's investigation report. Because SAIF's investigation report was not admitted in evidence, however, we are unable to determine whether or not that report presented an accurate history of claimant's work activities. Furthermore, although Dr. Collada commented that claimant was "mostly symptomatic in the hand that she was using mostly at work, his reports do not establish whether he meant her right or left hand. Claimant is right-handed and Dr. Collada's initial chart note reflected that fact. (Tr. 12, Ex. 8). Nevertheless, her symptoms began on the left side and she subsequently had symptoms on the right side. (Exs. 3, 8). Claimant's nerve conduction studies showed that her CTS was worse on the left side. (Exs. 5, 6). Thus, the medical evidence indicates that claimant was mostly symptomatic on the left side, even though she was right-handed. Because Dr. Collada's opinion is unclear and is not well-reasoned, it is not persuasive.

In addition, we find that Dr. Collada's comment that it was "very conceivable" that claimant's work activities "could have contributed" to her CTS establishes, at most, the possibility, not the probability, of a causal connection between claimant's work and her CTS condition. *See Gormley v. SAIF*, 52 Or App 1055 (1981). We conclude that, whether the claim is analyzed as an injury or an occupational disease, claimant has failed to establish compensability of her bilateral CTS.

ORDER

The ALJ's order dated October 2, 1998 is affirmed.

February 10, 1999 Cite as 51 Van Natta 245 (1999)

In the Matter of the Compensation of
TERRI A. BRIGGS-TRIPP, Claimant
Own Motion No. 94-0730M
OWN MOTION ORDER OF ABATEMENT
Foster A. Glass, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our January 12, 1999 Own Motion Order Reviewing Carrier Closure, in which we set aside the September 15, 1998 Notice of Closure as premature.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH R. OWEN, Claimant
WCB Case No. 98-01400
ORDER ON REVIEW
Robert J. Thorbeck, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant, through his out-of-state attorney, requests Board review of Administrative Law Judge (ALJ) Spangler's order that upheld the insurer's denial of claimant's claim for a right knee and low back injury. Contending that claimant's request for Board review is invalid because it was filed on claimant's behalf by an out-of-state attorney, the insurer moves for an order dismissing claimant's request for Board review. On review, the issues are dismissal and compensability. We affirm the ALJ's order with the following modification and supplementation.[1]

FINDINGS OF FACT

Claimant injured his right knee in 1975 while working for a Washington employer. Thereafter, claimant has undergone several surgeries. In 1979, claimant slipped as a result of chronic instability of the right knee, causing additional injury to the right knee as well as low back problems. Claimant also sustained an August 1994 right knee injury, again while working for a Washington employer.

In December 1996, claimant began to work for the employer in Oregon. His right knee pain gradually worsened, but he missed no time from work.

On November 5, 1997, claimant was walking up stairs at work while carrying an 80-pound starter motor. His right knee gave way as he was going up the stairs. Claimant fell injuring his right knee. Claimant then picked up the starter motor and strained his low back. Claimant sought medical treatment and filed a claim.

On February 2, 1998, the insurer denied claimant's injury claim. Claimant requested a hearing regarding the denial. In a November 23, 1998 order, the ALJ upheld the insurer's denial, finding that the major contributing cause of claimant's right knee and low back conditions was the preexisting condition due to the 1975 Washington State injury. Through his Washington attorney, claimant requested Board review of the ALJ's order. That request was mailed to the Board by certified mail on December 21, 1998.

CONCLUSIONS OF LAW AND OPINION

Motion for Dismissal

The insurer has moved for dismissal of claimant's request for Board review on the ground that the request is invalid since it was not filed by claimant personally and because claimant's out-of-state attorney, who filed the request, is not an Oregon attorney. In support of its argument, the insurer cites ORS 9.160 and OAR 438-006-0100. Having received claimant's response to the motion and the insurer's reply, we proceed with our consideration of the motion. Based on the following reasoning, we deny the motion to dismiss.

ORS 9.160 provides: "Except for the right reserved to litigants by ORS 9.320[2] to prosecute or defend a cause in person, no person shall practice law or represent that person as qualified to practice law unless that person is an active member of the Oregon State Bar." OAR 438-006-0100(1) provides: "Except as permitted by ORS 656.291 and this rule, corporations and state agencies must be represented by members of the Oregon State Bar. The Board encourages injured workers also to be represented in formal hearings."

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[1] Claimant's position has been presented in response to the insurer's motion for dismissal. Thus, a standard briefing schedule has not been implemented. Nonetheless, since the parties have each availed themselves of opportunities to advance their respective written arguments, we consider it to be in the interests of substantial justice to proceed with our review at this time.

[2] ORS 9.320 provides, in relevant part: "Any action, suit or proceeding may be prosecuted or defended by a party in person, or by attorney except that the state of a corporation appears by attorney in all cases, unless otherwise specifically provided by law."

In *Oregon State Bar v. Smith*, 149 Or App 171, 183 (1997), the court defined the "practice of law" as used in ORS 9.160 as "the exercise of professional judgment in applying legal principles to address another person's individualized needs through analysis, advice or other assistance." In the present case, we are not persuaded that the mere filing of a request for Board review in a workers' compensation matter falls within the definition of the practice of law. To be more specific, we are not persuaded that appealing an ALJ's order requires the use of "professional judgment in applying legal principles." In addition, there is no indication that the filing of the request involved legal analysis, advice or other assistance other than the essentially clerical act of requesting Board review.

The insurer also cites OAR 438-006-0100. This rule requires that certain entities (state agencies and corporations) be represented by attorneys. The rule encourages that injured workers be represented in "formal hearings," but does not require that requests for Board review be filed by Oregon attorneys.[3]

In summary, we are not persuaded that either ORS 9.160 or OAR 438-006-0100 requires the dismissal of claimant's request for review. The insurer has presented no authority or argument, and we are aware of no authority, that supports the proposition that the filing of a request for review in an administrative proceeding by an out-of-state attorney renders the request for review itself invalid. Accordingly, we deny the motion to dismiss.

Compensability

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

The ALJ found that claimant had not established that his November 5, 1997 injury in Oregon was the major contributing cause of his disability and need for treatment of his combined right knee and low back conditions under ORS 656.005(7)(a)(B).

In his response to the insurer's motion for dismissal, claimant seeks additional findings of fact that reflect that his August 1994 Washington injury, rather than solely his 1975 Washington injury, caused his November 1997 fall injury in Oregon.[4] In concluding that claimant had not established compensability of the November 1997 Oregon injury under ORS 656.005(7)(a)(B), the ALJ concluded that the November 1997 low back and right knee injury was caused by the 1975 Washington injury.

For purposes of Oregon law, the only relevant issue is whether the November 5, 1997 injury is the major contributing cause of the disability or need for treatment of claimant's current combined condition. Because it is unnecessary, for purposes of claimant's November 1997 Oregon claim, to determine whether a Washington injury or combination of injuries is the major cause of claimant's current condition, we modify the ALJ's order to delete the conclusion that the 1975 injury is the cause of the 1997 Oregon fall injury. Thus, we modify the ALJ's order to the extent that it finds that claimant's current disability and need for treatment is causally related to the 1975 Washington injury. Specifically, we delete the conclusions numbered 1 through 5 on page 3 of the order. Instead, we conclude that the major contributing cause of claimant's current low back and right knee conditions is the preexisting condition. We do not comment on which Washington injury, or combination of injuries is the major contributing cause of claimant's current conditions and need for treatment.

ORDER

The ALJ's order dated November 23, 1998 is affirmed.

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[3] In this respect, the filing of a request for Board review is not unlike the filing of a hearing request. *See Donald L. Grant*, 49 Van Natta 250 (1997) (hearing request filed by a corporate employer did not violate ORS 9.320 because the request preceded the actual commencement of a "proceeding," *i.e.*, the hearing).

[4] Noting that claimant is only seeking "additional findings of fact regarding his Washington claim," the insurer contends that there is no basis for his appeal because he is not requesting that the ALJ's order "be set aside or in any way changed." As explained in this order, claimant is not asking us to overturn the insurer's denial of his Oregon claim. Nonetheless, he is expressing dissatisfaction with other portions of the ALJ's order. Under such circumstances, we are authorized to proceed with our review. ORS 656.295(6) (Board may affirm, reverse, modify ALJ's order or take any other action it deems appropriate).

In the Matter of the Compensation of
GILBERT M. SANCHEZ, Claimant
WCB Case No. 98-01845
ORDER ON REVIEW
Bischoff, Strooband, 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) Mongrain's order that: (1) set aside its alleged "de facto" denial of claimant's claim for a new medical condition; and (2) awarded a $3,200 attorney fee pursuant to ORS 656.386(1)(b)(C). On review, the issues are "de facto" denial, claim processing, and attorney fees. We affirm.

FINDINGS OF FACT

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

On November 7, 1995, claimant suffered a left foot and ankle injury when a large log rolled onto his left foot and ankle. He was treated at an emergency room for a left ankle soft tissue injury and filed a workers' compensation claim on the same day. On November 22, 1995, the insurer accepted a disabling left ankle and foot sprain.

In December 1995, radiographs showed no fracture of the left foot and a normal ankle. Claimant continued to complain of pain at the left foot arch and the plantar surface at the region of the third, fourth and fifth metatarsophalangeal joints, especially with weight-bearing and walking. In March 1995, Dr. Lilly, orthopedist, found limitation of motion in the foot and ankle and mild swelling at the mid foot. Lilly noted no preexisting or degenerative processes in the left foot or ankle, and a June 5, 1996 imaging study of the left foot and ankle was again interpreted as normal.

On June 13, 1996, Dr. Denham noted that claimant had pain at the top of the left foot, tenderness over the dorsum of the left foot, limitation of rotation, and tenderness along the arch.

In August 1996, Dr. Auerbach, orthopedist, evaluated claimant. A bone scan was interpreted as consistent with a severe traumatic arthropathy or fracture; a subsequent CT scan was read to rule out a fracture.

In February 1997, Dr. Sampson noted that claimant was walking with an antalgic gait and holding the left foot in an inverted position with the hallux dorsiflexed. After imaging and nerve conduction studies, Dr. Sampson diagnosed post-traumatic arthritis of the left foot with pain following a crush injury. Sampson opined that no further care was warranted at that time, but noted that claimant might need arthrodesis of the navicular cuniform joint of the left foot.

The insurer issued a June 26, 1997 Notice of Closure that awarded 8 percent left foot scheduled permanent disability. A September 29, 1997 Order on Reconsideration affirmed the Notice of Closure in all respects; the Order on Reconsideration was affirmed by an April 3, 1998 Opinion and Order.

Meanwhile, on June 24, 1997, claimant had changed his attending physician to Dr. Naugle, and, in November 1997, Dr. Beaman, on referral by Naugle, began an evaluation of claimant's left foot pain and deformity.

On February 12, 1998, claimant requested that the insurer "expand the scope of accepted conditions to include the post-traumatic arthritis of the left first and second cuniform bones and navicular tarsal bone." On February 25, 1998, the insurer responded, stating: "[W]e feel the condition of post-traumatic arthritis of the left first & second cuniform bones & navicular tarsal bone is covered under our current Notice of Acceptance."

On March 2, 1998, claimant requested a hearing, raising the issues of a "2/25/98 denial" and "challenge to notice of acceptance ORS 656.262." The insurer's response to issues denied that a condition had been incorrectly omitted (scope of acceptance), and that "no *de facto* denial exists. The claimed condition is contemplated within the original acceptance."

On March 10, 1998, Dr. Beaman found significant uptake at the second tarsometatarsal joint articulation on the bone scan and that both a CT and MRI confirmed arthrosis in that region. Beaman recommended either a full length carbon fiber insert, nonoperatively, or a mid-foot arthrodesis operative procedure (fusion).

On May 26, 1998, preliminary authorization was sought for left mid-foot arthrodesis surgery.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's attorney's February 12, 1998 letter requesting that the insurer expand the scope of its acceptance to include "post-traumatic arthritis of the left first and second cuniform bones and navicular tarsal bone" was a request for a new medical condition under ORS 656.262(7)(a). Because the insurer neither accepted nor denied the condition within 90 days, the ALJ found that the condition had been "de facto" denied and awarded claimant an attorney fee under ORS 656.386(1)(b)(C) for prevailing over a denied claim.

On review, the insurer argues that claimant's attorney's February 12, 1998 letter was an objection to the employer's Notice of Acceptance under ORS 656.262(6)(d) for which the insurer had 30 days to respond, and, because the insurer stated that the requested conditions had been included in claimant's accepted "left ankle and foot strain" within 30 days of claimant's objection, no attorney fee may be awarded under ORS 656.386(1)(b)(C).[1]

We have previously addressed the distinction between a new medical condition under ORS 656.262(7)(a) and a condition that is incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) in *Mark A. Baker*, 50 Van Natta 2333 (1998). After examining the text and context of the statutes pursuant to the analysis set forth in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993), we found that a new medical condition under ORS 656.262(7)(a)[2] is one that comes into being following the issuance of the Notice of Acceptance, and 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. *Baker*, 50 Van Natta at 2336.

In the present case, the insurer contends that the condition of "post-traumatic arthritis of the left first and second cuniform bones and navicular tarsal bone" was contained within the diagnosed "left ankle and foot sprain" condition that was already accepted, and that, because it issued a "clarification" within the statutory 30 days, claimant must prove a "de facto" denial rather than rely upon the statute in order to establish his entitlement to an attorney fee. We disagree.

At the time of the insurer's November 22, 1995 Notice of Acceptance, x-rays of the foot and ankle were within normal limits and claimant had been diagnosed with a contusion or soft-tissue injury of the left foot and ankle. The insurer contends that the conditions claimed in the February 22, 1998 letter were contained within the diagnosed conditions that were already accepted. However, the medical record reveals that the post-traumatic arthritis of the left first and second cuniform bones and navicular tarsal bone came into being well after the November 22, 1995 Notice of Acceptance.

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[1] 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)(C) provides:

"(b) for purposes of this section, a "denied claim" is:

"* * * * *

"(C) A claim for an aggravation or new medical condition, made pursuant to ORS 656.262(7)(a), which the insurer or self-insured employer does not respond to within 90 days."

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

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims.

It was only after a September 5, 1996 bone scan that a diagnosis of either severe traumatic arthropathy or fracture of the left foot was entertained by Dr. Auerbach. (Ex. 8-5). And it was not until April 1997 that Dr. Sampson interpreted imaging studies as showing post traumatic changes at the navicular cuniform area of the left foot, which he diagnosed as mild post-traumatic arthritis of the left foot. (Ex. 16). 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 from that document.

Moreover, to the extent that the insurer's "clarification" could be interpreted as a contention that it need not separately accept the additional conditions because the existing acceptance "reasonably apprise[d] the claimant" of the nature of the compensable conditions, we note that such an argument is most appropriately made under the "new medical condition" provisions of the statute. *See* ORS 656.262(7)(a) ("The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularily, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions"). In this regard, we conclude that the acceptance of a "left ankle and foot strain" does not reasonably apprise claimant of the acceptance of his post-traumatic arthritis.

On this basis, we find that claimant's attorney's February 22, 1998 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.[3]

In sum, applying ORS 656.262(7)(a) to the facts of this case, claimant's attorney's February 22, 1998 letter clearly requested formal written acceptance of the post-traumatic arthritis of the left first and second cuniform bones and navicular tarsal bone 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. Finally, because the new conditions were not processed within 90 days in compliance with ORS 656.262(7)(a), the ALJ appropriately awarded an attorney fee under ORS 656.386(1)(b)(C) for a denied claim.[4]

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

ORDER

The ALJ's September 25, 1998 order is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the insurer.

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[3] Even if the February 22, 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) because claimant's traumatic arthritis came into existence after the Notice of Acceptance.

[4] Because we have established that claimant made a claim for a new medical condition and that the insurer failed to process the claim within the required statutory period, claimant is statutorily entitled to an attorney fee for a "denied claim." ORS 656.386(1)(b)(C). Therefore, we need not address the insurer's arguments regarding whether claimant established a "de facto" denial.

In the Matter of the Compensation of
EDWARD R. SCHOFIELD, Claimant
WCB Case No. 97-01916
ORDER ON REVIEW
Burt, Swanson, Lathen, et al, Claimant Attorneys
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 injury and occupational disease claims for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following corrected and supplemental findings and alternative rationale.

In lieu of the ALJ's finding that "claimant has generally been employed as a truck driver since approximately 1989", we find that claimant began working as a truck driver in or around 1974. We also find that claimant sustained an L4-5 disk herniation on or around October 9, 1996.

We turn to the ALJ's conclusions of law and opinion. The only medical opinion supporting compensability is from the treating physician, Dr. Bradbury. In concluding that Dr. Bradbury's opinion was not persuasive, the ALJ noted the contrary opinion of Dr. Donahoo. Claimant contends that Dr. Donahoo's opinion must be discounted because it is based on an inaccurate history of constant shooting pain down the left leg since approximately 1988. However, independent of any reliance on Dr. Donahoo, the ALJ set forth a number of other persuasive reasons why Dr. Bradbury's contrary opinion was not persuasive, including claimant's preexisting history of lumbar spondylosis, degenerative disc disease and chronic low back pain, the conclusory nature of Dr. Bradbury's opinion, and the contrary opinion of Dr. White. We affirm the ALJ's ultimate decision based on this independent rationale.

ORDER

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

In the Matter of the Compensation of
MARY A. TAYLOR, Claimant
WCB Case No. 98-04691
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its compensability and responsibility denial of claimant's injury claim for a disc herniation at L5-S1. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1]

We change the first paragraph of the findings of fact to read:

"On October 20, 1997, claimant, a photograph assistant, injured her lower back while taking camera equipment out of a car and bringing it into a school. (Exs. 2, 3). Liberty accepted a nondisabling lumbosacral sprain. (Ex. 6). Claimant quit working for Liberty's insured during the second week of December 1997. (Exs. 28, 29)."

On page 3, we replace the last paragraph with the following:

"Second, although Liberty argues that Drs. Dinneen and Melson did not properly weigh claimant's preexisting condition, we disagree. In their report, Drs. Dinneen and Melson discussed claimant's 1996 L5-S1 discectomy by Dr. Louie. (Exs. 27-3, -4, -6). Notwithstanding claimant's previous surgery, they concluded that her October 20, 1997 injury was the major contributing cause of the disc herniation at L5-S1. (Exs. 27-7). They attributed claimant's need for time loss to the 1997 incident, rather than the preexisting condition. (Ex. 27-6). They also found that claimant's intervening injury at another employment was 'of no measurable consequence' to her current lumbar condition. (Ex. 27-7). We find that Drs. Dinneen and Melson adequately evaluated the relative contribution of other possible causes of claimant's L5-S1 disc herniation."

L5-S1 Disc Herniation

Liberty argues that claimant was not a credible witness and her lack of credibility defeats the claim. The ALJ did not make any express credibility findings. We infer, however, that the ALJ found claimant credible because his findings of fact are based in part on claimant's testimony. *See Erck v. Brown Oldsmobile*, 311 Or 519, 527 n. 7 (1991). When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

Claimant, a photograph assistant, injured her lower back while lifting camera equipment out of a car and bringing it into a school on October 20, 1997. (Exs. 2, 3). Drs. Dinneen and Melson examined claimant on behalf of Liberty and reported that claimant's back and leg symptoms persisted after the October 20, 1997 injury. (Ex. 27-2). Liberty argues that their finding is inconsistent with the medical records.

The finding of persistent back and leg symptoms by Drs. Dinneen and Melson is consistent with claimant's testimony. She testified that she had severe pain down both legs during the holidays in 1997, as well as bad back spasms. (Tr. 15). She continued working until the season ended in December 1997. (*Id.*) Although her condition improved with treatment, claimant continued to have stiffness and pain down her legs. (Tr. 29). She testified that the back and leg symptoms had persisted since the October 1997 injury. (Tr. 37).

[1] We modify the ALJ's order to note that Exhibits 1 through 29, 5A and 27A were admitted in evidence.

Claimant acknowledged that the chart notes in December 1997, January 9, 1998 and January 22, 1998 did not refer to back or leg pain. (Tr. 26, 27). She testified that she had discussed her back and leg pain with Ms. Ryland, a physician's assistant, and Dr. Shonerd, but she felt that might not have been recorded because of the concern at that time about her mental condition and anti-depressant medication. (Tr. 27). The chart notes during that time frame referred to claimant's problems with anxiety and depression, as well as suicidal thoughts. (Ex. 5A). Claimant's complaints on December 16, 1997 also included "migrating body aches[.]" (Ex. 5A-2). On January 29, 1998, Ms. Ryland reported that claimant "has been having severe back pain with radiculopathy down both legs, dragging her lt. leg." (Ex. 7-1).

After reviewing the record, we are not persuaded by Liberty's argument that claimant was not a credible witness. Her testimony is consistent with her reports to Drs. Dinneen and Melson. Although the chart notes in December 1997 and early January 1998 did not refer to claimant's back and leg symptoms, we are persuaded by claimant's testimony that, although she improved with treatment, she continued to have back and leg symptoms. The January 29, 1998 chart note indicating claimant "has been having" back and leg pain is consistent with claimant's testimony, as is the reference in the December 16, 1997 chart note to migrating body aches.

In any event, we agree with claimant's argument that none of the physicians in this case indicated that a history of back and leg complaints between November 1997 and January 1998 was essential to determining that the October 1997 injury was the major contributing cause of her disc herniation. Drs. Dinneen and Melson reviewed claimant's medical records and referred specifically to the chart notes from Ms. Ryland and Dr. Shonerd between October 1997 and January 1998. (Ex. 27-4). They noted that claimant had seen Ms. Ryland about "various medical problems, mostly those associated with the need and or use of Effexor." (*Id.*) Drs. Dinneen and Melson were also aware of claimant's 1996 L5-S1 discectomy by Dr. Louie. (Exs. 27-3, -4, -6). Nevertheless, they concluded that claimant's October 20, 1997 injury was the major contributing cause of the disc herniation at L5-S1. (Exs. 27-7). They attributed claimant's need for time loss to the 1997 incident rather than the preexisting condition.

The opinion of Drs. Dinneen and Melson is supported by the opinion of claimant's treating physician, Dr. Shonerd, who opined that the October 1997 injury was the most likely cause of her herniated disc. (Ex. 15). There are no contrary medical opinions on causation. We agree with the ALJ that claimant has established compensability of the L5-S1 disc herniation.[2]

Claimant's attorney is entitled to an assessed fee for services on review regarding the L5-S1 disc herniation. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 9, 1998, as amended October 16, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by Liberty.

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[2] Claimant filed a claim for a disc herniation at L4-5 and L5-S1. (Exs. 17, 23). Although Liberty's August 12, 1998 denial referred only to an L4-5 disc herniation (Ex. 27A), Liberty amended its denial at hearing to include an L5-S1 disc herniation. (Tr. 2). Although the earlier records indicated that claimant had a herniation at L4-5 (Ex. 15), the later medical reports established that she actually had a disc herniation at L5-S1 instead. (Exs. 20, 21).

In the Matter of the Compensation of
JOSEPH C. VONDRACHEK, Claimant
WCB Case No. 98-02637
ORDER ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

On December 23, 1998, we abated our December 17, 1998 order that reversed the Administrative Law Judge's (ALJ's) order which 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 in our original order 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, we abated our 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 issued an Order of Abatement on our own motion. Inasmuch as we have issued our order on reconsideration in *Ganer*, we now proceed with our reconsideration in this case.

On reconsideration of our order in *Ganer*, we held that, in determining the compensability of the claimant's compensable injury-related mental condition, the "consequential condition" standard of ORS 656.005(7)(a)(A) was applicable. 51 Van Natta 116 (1999). In *Ganer*, following the claimant's compensable low back injury, her physician diagnosed a depression condition. Asserting that her compensable injury was the major contributing cause of her depression, the claimant contended that her depression was compensable as a "consequential condition" under ORS 656.005(7)(a)(A).

Although we originally held in *Ganer* that all claims for mental disorders must be analyzed under ORS 656.802, we held on reconsideration that the applicable statute for consequential condition claims for mental disorders was ORS 656.005(7)(a)(A). Citing *Boeing Co. v. Viltrakis*, 112 Or App 396, 399 (1992); and *Aetna Casualty Co. v. Robinson*, 115 Or App 154, 156-57 (1992), we concluded that when a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply.

We acknowledged that, in *Fuls v. SAIF*, 321 Or 151 (1995), the Supreme Court observed that ORS 656.802 applies to "any mental disorder." Notwithstanding that statement, we noted that the Court was addressing the argument that the claimant could prove a compensable mental disorder under an "injury" theory and was not analyzing the question of whether ORS 656.802 applies to a "consequential" mental disorder. Moreover, we reasoned that the Supreme Court's statement supported the *Viltrakis* rationale in that the claimant's claim in *Fuls* was an "independent," not a "consequential," claim.

Inasmuch as the claimant was alleging that her compensable low back injury caused her depression, we concluded that the major contributing cause standard of the "consequential condition" statute (ORS 656.005(7)(a)(A)) applied. Because evidence did not establish that the claimant's compensable injury was the major contributing cause of her depression, we upheld the carrier's denial.

Here, claimant alleged that his compensable low back injury caused his mental disorder. In accordance with our decision in *Ganer*, we also conclude that the major contributing cause standard of the consequential condition statute (ORS 656.005(7)(a)(A)) applies in this case.[1] We now proceed to analyze this case under that statute, which requires that the original compensable injury be the major contributing cause of the consequential condition. *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992) (holding that, when a condition or need for treatment is caused by the compensable condition, as opposed to the industrial accident, the major contributing cause standard is applied).

In our original order, we found that claimant had failed to prove by "clear and convincing evidence" that his mental disorder condition arose out of and in the course of employment under ORS 656.802(3)(d). Consequently, we reversed the ALJ's order.

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[1] We note that this is the standard that the ALJ applied in finding that claimant's mental disorder was compensable.

In reaching our decision, we reviewed the medical opinions of the physicians who addressed the causation issue. We found the opinion of an examining psychiatrist, Dr. Turco most persuasive. We noted that he took a complete and accurate history and did not attribute claimant's condition to the compensable injury, but rather to noncompensable stressors including family problems and concerns regarding claim processing. In addition, we noted that psychologists from the Northwest Occupational Medical Center (NOMC) did not support compensability because they attributed claimant's mental condition to job loss, concerns about his vocational future and his ability to provide for his family rather than the compensable injury. Finally, we did not find the opinion of a social worker, Ms. Kern, who treated claimant persuasive because she did not discuss or weigh claimant's nonwork stressors prior to reaching her conclusion that claimant's depression was due to the industrial injury.[2]

Although we are now applying a different legal standard (major contributing cause under ORS 656.005(7)(a)(A)) in evaluating the compensability issue, we find that the same reasons we discounted the NOMC and Kern opinions apply equally to the major contributing cause standard as they did to the "clear and convincing" standard that we previously applied. That is, for the same reasons we found those opinions unpersuasive in establishing that claimant's mental condition arose out of and in the course of employment, we also find them insufficient to prove that the compensable injury is the "major contributing cause" of the consequential psychological condition. *Jackie T. Ganer*, 51 Van Natta at 118.

Accordingly, we conclude that claimant's mental disorder is not compensable under ORS 656.005(7)(a)(A). Therefore, on reconsideration, as supplemented and modified herein, we adhere to and republish our December 17, 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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[2] The employer objected to the admissibility of Ms. Kern's opinion on the ground that she was unqualified to render an opinion. The ALJ overruled the employer's objection. (Tr. 6). We need not decide whether the ALJ's evidentiary ruling was correct. That is, even if we consider Ms. Kern qualified to render an opinion, we do not find it persuasive.

In the Matter of the Compensation of
EDWARD M. JOHNSTON, II, Claimant
Own Motion No. 98-0060M
OWN MOTION ORDER
Bischoff, Strooband, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer initially submitted claimant's request for temporary disability compensation for claimant's compensable acute neck strain. Claimant's aggravation rights expired on September 9, 1996. The insurer denied the compensability of claimant's current cervical disc herniation C5-6 condition. In addition, the insurer opposed reopening on the grounds that: (1) it was not responsible for claimant's current condition; (2) surgery or hospitalization was not reasonable and necessary for the compensable injury; and (3) claimant was not in the work force at the time of disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 98-03538).

On July 7, 1998, 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.

On December 21, 1998, Administrative Law Judge (ALJ) Spangler issued an Opinion and Order which set aside the insurer's denial. In doing so, ALJ Spangler found that claimant's cervical disc herniation at C5-6 was causally related to the November 1989 compensable injury. The ALJ's order has not been appealed.

Regarding the work force issue, ALJ Spangler concluded that claimant was in the work force at the time of his current worsening. ALJ Spangler found that claimant was last employed in December 1996 and, since that time, had submitted approximately 60 applications for employment. Based on such findings, ALJ Spangler determined that claimant was willing to work and has made reasonable efforts to seek work.

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

In 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. After reviewing this record, we share ALJ Spangler's findings that claimant was willing to work and was seeking work at the time his condition worsened requiring surgery.

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 March 8, 1998, claimant underwent anterior cervical fusion. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. Furthermore, as previously noted, we find that claimant was in the work force at the time of his disability.

Accordingly, we authorize the reopening of claimant's 1989 injury claim to provide temporary disability compensation beginning March 8, 1998, the date claimant was hospitalized. 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
WILLIAM F. DAVIS, JR., Claimant
WCB Case No. 98-03428
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that assessed a $2,000 attorney fee for services at hearing. SAIF moves to strike claimant's statement of services and an attached document. SAIF also moves for remand. In his respondent's brief, claimant requests that his fee award be increased to $4,000. On review, the issues are motion to strike and remand, and attorney fees. We deny the motion and 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" except for the last paragraph, with the following supplementation.

Motions

SAIF moves to strike claimant's counsel's statement of services and a document that appears to be an excerpt from a Hearings Division statistical report. We deny SAIF's motion, based on the following reasoning.

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's statistical submission 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.[1]

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 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).

Here, there is no indication that the proposed evidence was unobtainable at the time of hearing. Moreover, admission of the proposed evidence would not likely affect the outcome of the case. Therefore, remand is inappropriate. *See Compton*, 301 Or at 646. Accordingly, because we have not considered the statistical report on review, we need not address SAIF's motion to strike it. *See Maria Leyva*, 48 Van Natta 288 (1996) (Board will not consider evidence not previously made a part of the record).

Claimant's counsel's statement of services is a different matter. OAR 438-015-0029(1) specifically provides that a claimant's attorney *may* file a request for a specific attorney fee for services at the hearing level and/or for services on Board review (subject to procedural restrictions not relevant here). Accordingly, we deny SAIF's motion to strike claimant's counsel's statement of services.

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[1] We also acknowledge claimant's January 7, 1999 submission of a second respondent's brief (entitled "Respondent/Cross Appellant's Reply Brief), with a document attached. The document appears to be a letter from SAIF's claims adjuster listing certain reimbursed expenses. We have not considered the second brief on review, because claimant did not file a cross-request for review and his second brief is not otherwise authorized. *See* OAR 438-011-0020(2). We decline to remand the case for submission of the attached document (because it would not likely affect the outcome of the case) and we have not considered it on review. *See* ORS 656.295(5).

As a further preliminary matter, we address SAIF's motion for remand to supplement the record regarding the attorney fee issue. We deny the motion, because we may modify or supplement the ALJ's order on review and we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. *See Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998).

Attorney Fees

The ALJ set aside SAIF's partial denial of claimant's claim for a current cervical condition. The ALJ then assessed a $2,000 attorney fee, having considered the factors set forth in OAR 438-015-0010(4),

> "especially the time and effort devoted to this case, the value and nature of the results obtained for the injured worker, and the risk that claimant's attorneys may go uncompensated. Since this claim is in Own Motion status, and there has been no authorization of time loss, and the issue whether the proposed medical services are appropriate under the Oregon Workers' Compensation law has not been decided, the current value of this claim is limited to the philosophical question whether the current condition has sufficient connection to the compensable injury. Claimant will gain nothing as a result of this order alone." (Opinion and Order, p. 7).

We disagree that the compensability of claimant's condition is merely a "philosophical question" and we do not find that claimant gains "nothing" by establishing compensability. *See, e.g.*, ORS 656.245(1)(a)&(b).

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)."[2]

We considered the same argument in *Underwood*, 50 Van Natta 2330. There, the claimant's attorney did not submit a specific fee request at hearing 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.

Here, as in *Underwood*, claimant's attorney did not submit a statement of services or make a specific attorney fee request to the ALJ. 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.[3]

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[2] 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.

[3] *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).

Nonetheless, because SAIF has now advanced arguments challenging the sufficiency of the ALJ's order and claimant requests an increased fee[4] (and because further appellate review of our decision would be subject to the "range of discretion" criteria discussed in *Schoch*), we determine a reasonable attorney fee award as follows.

The issue at hearing was the compensability of claimant's degenerative disease of the cervical spine with stenosis and C6 and C7 radiculopathy. With regard to the time factor, we note that claimant has submitted a statement of services on review attesting to 13.5 hours of legal services at the hearings level. The hearing transcript is about 26 pages long and claimant was the only witness who testified. The record consists of about 53 exhibits, including 4 medical reports/opinion letters that established compensability of the claim and were submitted by claimant. No depositions were taken.

We find the legal and medical issues to be of average complexity, considering compensability disputes generally presented to the Hearings Division. Because the medical reports concerning causation were divided, there was a risk claimant's attorney would go uncompensated.[5] Finally, both attorneys presented their cases in a skillful manner.

Finally, claimant's counsel attests to over $6,000 of *incurred* claim related expenses, including medical treatment. (*See, e.g.*, Exs. 31-39, 41, 49, 50, 50A, 51). SAIF contends that claimant's entitlement to *proposed* medical services is merely speculative (because it has not yet determined whether such services would be appropriate). But claimant *is* entitled to medical services for his compensable condition under ORS 656.245 and SAIF does not dispute claimant's valuation of expenses already incurred. On the other hand, we note that the value of the interest, as well as the benefit secured -- in the form of medical services -- are *generally* considered to be rather modest.[6] Under these circumstances, we find that the value of the interest involved and the benefit secured for claimant (including future compensable medical expenses) are in the average range.

Based on these factors, especially the time devoted to the issue (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, the nature of the proceedings (26 page hearings transcript), and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $2,000 is a reasonable attorney fee. 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 October 27, 1998 is affirmed.

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[4] It is well-settled that a party may contest any portion of an ALJ's order in the absence of a timely cross-appeal, provided that the other party which requested review does not withdraw its request for review. *See Catherine E. Wood*, 47 Van Natta 2272, 2274 n. 1 (1995) (*citing Jimmie Parkerson*, 35 Van Natta 1247, 1249-50 (1983)). Because SAIF has not withdrawn its request for review, we address claimant's request for an increased attorney fee for services at hearing, noting that the request was raised in claimant's authorized respondent's brief. *See* OAR 438-011-0020(2); *see also* OAR 438-015-0029(1).

[5] We have previously declined to apply a contingency factor or "multiplier" in a strict mathematical sense. *See, e.g., Lois J. Schoch*, 49 Van Natta 788, 790, n.1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). We decline to do so in this case as well. Instead, in conjunction with the other relevant factors discussed above, 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.

[6] *See Melvin L. Martin*, 47 Van Natta 107, *on recon* 47 Van Natta 268 (1995); *Dwight E. Fillmore*, 40 Van Natta 794 (1988), *aff'd Weyerhaeuser Co. v. Fillmore*, 98 Or App 567, 571, *rev den* 308 Or 608 (1989); *Derry D. Blouin*, 35 Van Natta 570 (1983).

In the Matter of the Compensation of
MICHELLE M. GREEN, Claimant
WCB Case No. 97-04608
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Moscato & Hallock, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) limited her temporary partial disability benefits to a two year period pursuant to ORS 656.212; (2) rated claimant's permanent psychological impairment as Class 2, mild (23 percent); (3) increased claimant's unscheduled permanent disability award from 45 percent (144 degrees), as granted by an Order on Reconsideration, to 49 percent (156.8 degrees); and (4) declined to award an assessed fee under ORS 656.382(2) for her counsel's services at hearing. The self-insured employer cross-requests review, seeking a reduction of claimant's 49 percent unscheduled permanent disability award. On review, the issues are temporary disability, extent of unscheduled permanent disability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with two exceptions: We do not find that claimant's adaptability to post-injury work exceeds that recognized in the Order on Reconsideration, nor do we find that claimant's unscheduled permanent disability exceeds that awarded in the Order on Reconsideration. We summarize the pertinent facts as follows:

Claimant, age 33 at the time of hearing, was compensably injured in June 1991 while working as a customer service clerk at the employer's retail store. She was physically attacked by a customer, and sustained cervical and thoracic injuries as well as psychological trauma. The employer accepted disabling cervical and thoracic strains. After claimant underwent a psychological evaluation, the employer amended its acceptance to include post-traumatic stress.

Approximately six weeks after the incident (but prior to any diagnosis or treatment for a psychological condition), claimant attempted to return to full time work in a different position. She was unable to work full time because of her psychological condition, and Dr. Constein limited her to part time work. On December 16, 1991, Dr. Constein released claimant to return to full time work.

Claimant returned to full time work on January 6, 1992, but left this job in mid-February because of her psychological condition. In August 1992, Dr. Constein retroactively authorized time loss related to claimant's psychological trauma.

Meanwhile, in June 1992, claimant began treating with Dr. Martindale, a clinical psychologist. Dr. Constein continued to authorize time loss until Dr. Martindale released claimant back to work. In October 1992, Dr. Martindale released claimant to return to modified work, in a setting where she would not work directly with customers or be required to walk through the store.

A Settlement Stipulation approved on November 10, 1992 resolved a temporary disability dispute between the parties. Claimant was paid the sum of $800 for time loss for the period from June 6, 1992 to October 5, 1992.

Claimant continued to treat with Dr. Martindale on a weekly basis until March 1993. Thereafter, claimant sought intermittent treatment. In December 1994, Dr. Martindale released claimant for regular work in a corporate office setting. Dr. Constein similarly opined that claimant's physical injuries were medically stationary and that claimant could return to full-time work at the store's central office.

The claim was closed pursuant to an April 21, 1995 Determination Order, which awarded temporary total disability through September 27, 1994 and temporary partial disability from September 28, 1994 to December 20, 1994 along with 10 percent unscheduled permanent disability for the cervical injury.

Claimant requested reconsideration, seeking additional unscheduled permanent disability. On December 1, 1995, claimant was seen by Dr. Bellville for a psychiatric arbiter examination. Dr. Bellville reported that, although claimant's psychological condition had remained unchanged for some time, she could improve with further treatment if she was willing and motivated to do so. Thereafter, a December 27, 1995 Order on Reconsideration rescinded the Determination Order as premature.

In January 1996, Dr. Martindale reported that claimant's unwillingness to involve herself in treatment impeded her progress. Dr. Martindale also agreed that claimant's psychological condition probably prohibited her from returning to work as a customer service representative in the employer's store. In February 1996, Dr. Constein opined that claimant remained medically stationary with permanent impairment.

In March 1996, claimant was referred to Dr. Freeman for a psychiatric evaluation. Dr. Freeman opined that claimant was medically stationary with some residual psychiatric impairment. Dr. Freeman also reported that claimant had started a new job in January 1996, and was working well in that setting, although she continued to be unable to work at (or even enter) the employer's store. In follow up correspondence, Dr. Freeman noted that claimant's condition had improved since she was evaluated by Dr. Bellville in December 1995, and rated her current psychological impairment as Class 2, moderate.

The claim was reclosed pursuant to a December 18, 1996 Determination Order, which awarded temporary disability, less time worked, through December 22, 1994 and 62 percent unscheduled permanent disability.

Claimant requested reconsideration seeking additional temporary disability (through March 27, 1996). The employer cross-requested reconsideration, challenging the rating of unscheduled permanent disability and the dates of temporary disability.

On April 24, 1997, claimant saw Dr. Thomas for an orthopedic medical arbiter examination. On May 5, 1997, claimant saw Dr. Klein for a psychiatric arbiter evaluation. Dr. Klein rated claimant's psychological impairment as Class 2, mild.

A May 9, 1997 Order on Reconsideration awarded temporary disability for the period of June 16, 1991 through December 22, 1993,[1] less time worked, and reduced claimant's unscheduled permanent disability award to 45 percent.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

At hearing, claimant asserted that she was entitled to time loss for the period of December 22, 1993 through March 27, 1996, the date of Dr. Freeman's evaluation. The ALJ disagreed. Instead, the ALJ found that claimant's condition was medically stationary as of December 1994, and concluded that, under ORS 656.212(2), claimant was entitled to temporary partial disability for an "aggregate period" not exceeding two years prior to that date. The ALJ also found that, in addition to the two-year period, claimant was entitled to temporary total disability from February 24, 1992 through June 5, 1992.

On review, claimant argues that she is entitled to temporary total disability through March 27, 1996. In support of this contention, claimant contends that ORS 656.212(2) must be read together with ORS 656.268(3), and that, because she did not return to regular work and was not offered modified work (after 1991 or 1992), she remained entitled to temporary total disability benefits rather than temporary partial disability. We find to the contrary.

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[1] Specifically, the Order on Reconsideration noted that claimant was off work from June 17, 1991 to July 1, 1991, released for modified work from July 2, 1991 to July 9, 1991, and then off work until July 31, 1991, when she was again released for modified work. The Order on Reconsideration further found that claimant was taken off work again from February 14, 1992 to July 1, 1992, and authorized for modified work from that date on. The Appellate Reviewer concluded that, pursuant to the two-year aggregate period limitation for temporary partial disability benefits set forth in ORS 656.212(2), the award of temporary disability ended on December 22, 1993. (Ex. 43-2).

Because claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992). 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 at least partially disabled due to the compensable injury before being declared medically stationary. *See Santos v. Caryall Transport*, 152 Or App 322 (1998); *John P. Daugherty*, 50 Van Natta 1368 (1998).

Although ORS 656.268(3) requires that temporary total disability benefits continue until the worker either returns to or is released to regular work, or is released to modified work and such work is offered and refused, this statute governs procedural entitlement to temporary disability only. ORS 656.268 does not pertain to the determination of substantive entitlement to temporary disability, as those requirements are set forth in ORS 656.210 and 656.212. *See Kenneth P. Bundy*, 48 Van Natta 2501 (1996). Indeed, just as a worker's substantive entitlement to temporary disability is not contingent on an attending physician's "time loss" authorization, substantive entitlement to (or cessation of) temporary disability is also not contingent upon the employer's written offer of modified work and the worker's acceptance or refusal of such work. Rather, as noted above, substantive entitlement to temporary disability is dependent upon a preponderance of evidence in the record showing that the claimant was at least partially disabled due to the compensable injury before the accepted condition became medically stationary. *Id.; see also SAIF v. Taylor*, 126 Or App 658 (1994).

Here, a preponderance of evidence in the record establishes that by October 1992[2] claimant was capable of modified work. Indeed, at that time, Dr. Martindale released claimant to work so long as claimant was in a controlled environment and not working with the public. Dr. Martindale recommended that claimant not work directly with customers and not be required to walk through the store, although she considered claimant able to work. Dr. Constein, who treated claimant's physical injuries, repeatedly deferred to Dr. Martindale's recommendation on this issue. Consequently, on the merits, claimant has not established an entitlement to temporary total disability due to her accepted conditions for any period of time subsequent to October 5, 1992.

Pursuant to ORS 656.212(2), claimant is only entitled to temporary partial disability for an "aggregate period not exceeding two years." We therefore adopt and affirm the ALJ's determination on the temporary disability issue.

Extent of Unscheduled Disability

As set forth in the ALJ's order, the parties have two disputes concerning the extent of claimant's unscheduled permanent disability: (1) the impairment classification of claimant's psychoneurosis under *former* OAR 436-035-0400 (WCD Admin Order No. 96-051); and (2) the appropriate adaptability value.

With regard to the impairment classification, the ALJ concluded that claimant's impairment should be rated as Class 2, mild (23 percent). On review, claimant asserts that her impairment should be rated as Class 2, moderate (35 percent). The employer, on the other hand, argues that claimant's impairment should be rated as Class 1 (0 percent) or Class 2, minimal (6 percent).

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. *See 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 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).

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[2] As set forth above, claimant resolved all issues regarding her entitlement to temporary partial and total disability for the period of June 6, 1992 to October 5, 1992 pursuant to the parties' November 10, 1992 Settlement Stipulation. (Ex. 13).

Here, we agree with the ALJ that Dr. Klein, who performed a psychiatric arbiter evaluation in May 1997, provides the most reliable evaluation of claimant's mental impairment as of the date of issuance of the Order on Reconsideration. Dr. Klein explained that, as a result of the assault at work, claimant became fearful and avoided areas that provoked her fears. Dr. Klein found that claimant had some mild residual symptoms that constrict her activities going out alone in certain places. In concluding that claimant's impairment was in the Class 2, mild category, Dr. Klein noted that claimant has "anxiety with feelings of tension that occasionally limit her activity, brief mild phobic reaction under usually avoidable conditions and somewhat overly rigid responses."

Former OAR 436-035-0400(5)(b) provides that a worker belongs in Class 2 when one or more residual reactions are noted, including the following:

> "(A) Anxiety Reactions: May require extended treatment. Specific reactions may include (but are not limited to) startle reactions, indecision due to fear, fear of being alone and insomnia. There is no loss of intellect or disturbance in thinking, concentration or memory.
>
> "* * * * *
>
> "(C) Phobic Reactions: Interfere with normal activities to a mild or moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms and an obvious reaction of fear when confronted with a situation which involves a superstition."

After considering Dr. Klein's findings and conclusions in light of the provisions of *former* OAR 436-035-0400(5), we agree that claimant's residual reactions place her in the Class 2, mild category. We agree with the ALJ and the Appellate Review Unit that claimant is entitled to a value of 23 percent for her residual psychiatric impairment.

We disagree, however, with the ALJ's calculation of claimant's adaptability value in this case. The applicable provisions, *former* OAR 436-035-0310(8) and (9), provide as follows:

> "(8) For those workers who have ratable unscheduled impairment found in rules OAR 436-035-0380 through 436-035-0450, adaptability is determined by comparing the worker's extent of impairment to the following Adaptability Scale:

Total Impairment	Adaptability Value
0-4%	0
5-9%	1
10-19%	2
20-29%	3
30-39%	4
40-49%	5
50-59%	6
60 % and over	7

> "(9) For those workers who have ratable unscheduled impairment found in rules OAR 436-035-0320 through 436-035-0375 and also unscheduled impairments in rules OAR 436-035-0380 through 436-035-0450 in the same claim, adaptability shall be determined by comparing both the adaptability scale in section (8) of this rule with the residual functional capacity scale in section (5) of this rule, and using the higher of the two values for adaptability."

Although the first column in the "Adaptability Scale" set forth in OAR 436-035-0310(8) is labeled "Total Impairment," we do not construe this phrase to mean the impairments of all body parts or systems. Rather, we conclude that, for purposes of this subsection's Adaptability Scale, the "Total Impairment" is limited to the "total impairment ratable under OAR 436-035-0380 through 436-035-0450." We therefore decline to include impairment values for unscheduled body parts (*i.e.*, those conditions

ratable under OAR 436-035-0320 to 436-035-0375) in determining adaptability under OAR 436-035-0310(8). We find support for this construction in OAR 436-035-0310(9), as that provision requires that when a worker has ratable impairment for both an unscheduled body part (rated under OAR 436-035-0320 to 436-035-0375) and a body system or mental disorder (rated under ORS 436-035-0380 to 436-035-0450), the adaptability value for the former shall be compared to the adaptability value for the latter, and the higher of the two values should be used. To combine the total impairments of all body parts and systems for purposes of subsection (8) would skew that section's adaptability scale.

Consequently, in this case, where claimant's total impairment ratable under OAR 436-035-0380 through 436-035-0450 is the 23 percent impairment value awarded under OAR 436-035-0400(5), claimant's adaptability value under subsection (8) of OAR 436-035-0310 is 3. Pursuant to subsection (9) of OAR 436-035-0310, we compare that adaptability value to the value claimant would be entitled for her residual functional capacity (RFC) under subsection (6) of OAR 436-035-0310.

The record establishes that claimant's base functional capacity (BFC) is light, and that her RFC is light. Therefore, pursuant to the residual functional capacity scale in subsection (6), claimant's adaptability value would be 1. We use the higher of the two adaptability values (3) in calculating claimant's unscheduled permanent disability award. *Former* OAR 436-035-0310(9).

Assembling the various factors pursuant to OAR 436-035-0280 (0 for age, 1 for education plus 3 for skills equals 4, multiplied by an adaptability value of 3 for a total age/education/adaptability value of 12 which is added to the impairment value of 33[3]), we find that claimant is entitled to a total unscheduled permanent partial disability award of 45 percent, as set forth in the May 9, 1997 Order on Reconsideration.

Attorney Fee

Noting that the employer argued at hearing that claimant's unscheduled permanent disability award should be reduced from the 45 percent awarded by the Order on Reconsideration,[4] claimant contends that the ALJ erred in not awarding an assessed attorney fee (in addition to the "out-of-compensation" fee). Although we have disallowed the ALJ's award of an additional 4 percent unscheduled permanent disability on review, claimant is correct that his counsel is entitled to an assessed fee under ORS 656.382(2) for services at hearing because the Order on Reconsideration's award was not disallowed or reduced.

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 in defending the Order on Reconsideration's unscheduled permanent disability award 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.

ORDER

The ALJ's order dated September 12, 1998[5] is affirmed in part and reversed in part. In lieu of the ALJ's award of an additional 4 percent unscheduled permanent disability (for a total award of 49 percent), we affirm the Order on Reconsideration's award of 45 percent (144 degrees) unscheduled permanent disability. The accompanying "out-of-compensation" attorney fee is also reversed. In addition, for services at hearing, claimant's counsel is awarded $1,500, payable by the employer. The remainder of the ALJ's order is affirmed.

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[3] This value consists of 23 percent for claimant's residual psychiatric impairment combined with the 13 percent impairment related to her accepted cervical and thoracic conditions.

[4] *See* Tr. at pp. 1-2.

[5] Although the ALJ's order is actually dated September 12, 1997, that year date is a clerical error.

In the Matter of the Compensation of
MARK A. KLOUDA, Claimant
WCB Case No. 97-02961
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) assessed a penalty for the insurer's allegedly unreasonably late payment of medical bills; and (2) awarded an assessed attorney fee for the insurer's allegedly unreasonable resistance to the payment of compensation. In addition, claimant argues that the insurer's request for review is defective and all relief should be denied. We treat claimant's argument as a motion to dismiss. On review, the issues are dismissal, penalties, and attorney fees. We deny the motion to dismiss and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, corrections, supplementation, and summary. We do not adopt the first two sentences of the ninth paragraph.

The last sentence of the third paragraph of the findings of fact should read: "[The insurer's] *acceptance* reasonably advised claimant and his medical providers that the tendon disruption was part of the accepted claim."

The date in the first sentence of the seventh paragraph of the findings of fact should be "September 17, 1997." (Ex. 37-1).

Claimant was employed as a mechanic at a bowling alley. On November 12, 1996, claimant fell into a pin-setting machine and impaled his left forearm on a piece of equipment. Claimant's arm remained impaled approximately 45 minutes while attempts were made to extricate him. He had emergency surgery on his forearm on the same day. On November 18, 1996, Dr. Achterman, treating surgeon, noted claimant sustained a disruption of the extensor digitorum communis. (Ex. 9).

On February 3, 1997, the insurer accepted a disabling "left schrapnel [sic] injury with left radioal [sic] nerve lesion." (Ex. 22).

On February 7, 1997, claimant requested that the insurer amend its acceptance to include disruption of the extensor digitorum communis. (Ex. 24).

On April 8, 1997, claimant filed a request for hearing, raising issues of compensability, challenge to the Notice of Acceptance, temporary total disability rate, penalties and attorney fees. On May 21, 1997, the insurer submitted a "Response to Issues," denying "that the [insurer] has denied the compensability of this claim" and stating that "no conditions have been denied. The claim is accepted. All benefits have been paid."

On May 29, 1997, the insurer amended its acceptance to include disruption of the left extensor digitorum communis. (Ex. 32).

On May 29, 1997, Dr. Van Allen examined claimant and first mentioned the possibility of psychiatric problems. (Ex. 32A). He prescribed "psychiatric evaluation for coping, post traumatic stress [disorder (PTSD)]." (Ex. 32B).

On June 26, 1997, claimant requested that the insurer amend its acceptance to include left hand extensor tendon adhesions and PTSD. (Ex. 33).

On June 30, 1997, claimant was examined by Dr. Kolilis, psychologist, who diagnosed PTSD and recommended treatment. (Exs. 34, 51). Dr. Kolilis provided psychological treatment through November 18, 1997. (Ex. 51).

On July 10, 1997, the insurer amended its acceptance to include left hand extensor tendon adhesions. (Ex. 34B).

On September 17, 1997, Dr. Klein, M.D., performed a psychiatric evaluation of claimant on behalf of the insurer and diagnosed anxiety with phobic response. (Ex. 37). Although Dr. Klein did not agree with Dr. Kolilis, claimant's treating psychologist, that claimant had "full blown" PTSD, she did not feel their disagreement in terms of the diagnosis was significant. (Ex. 37-5).

On October 1, 1997, claimant filed a supplemental request for hearing, raising issues of compensability of PTSD, partial denial after claim acceptance, challenge to the Notice of Acceptance, and attorney fees.

On October 15, 1997, the insurer amended its acceptance to include anxiety with phobic response. (Ex. 40).

In late 1997, claimant treated with Dr. Kinzie, psychiatrist, for severe PTSD, exacerbated by a relapse at the anniversary date of the work injury. (Ex. 46).

By a partial stipulation dated February 9, 1998, the parties resolved the issues regarding claimant's time loss rate and penalties and attorney fees related to the time loss rate. This partial stipulation, however, specifically stated that it did not affect claimant's challenges to the Notice of Acceptance, compensability, penalties and attorney fee issues raised in the hearing requests dated April 8, 1997 and October 1, 1997. These issues were set for hearing on February 25, 1998.

On February 25, 1998, the day the hearing was set, the insurer amended its notice of acceptance to include PTSD. The parties agreed to have the ALJ resolve the remaining issues on the written record without a hearing.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The ALJ amended the July 22, 1998 order on July 23, 1998. This amended order specified the percentage of the penalty assessed in the initial order. Furthermore, the amended order stated that: (1) the initial order remained as published in all other respects; and (2) the appeal rights continued to run from July 22, 1998, the date the initial order was published. Claimant argues that, although the insurer requested review of the ALJ's July 22, 1998 order, it failed to request review of the ALJ's July 23, 1998 amended order. Claimant apparently reasons that the expired appeal rights on the July 23, 1998 amended order preclude the insurer from now appealing the amended order, rendering the insurer's request for review defective. As a result, claimant contends that all relief should be denied. We treat claimant's argument as a motion to dismiss. For the following reasons, we deny that motion.

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for adjudication. *Nollen v. SAIF*, 23 Or App 420, 423 (1975).

The time within which to appeal an order continues to run unless the order has been "stayed," withdrawn or modified. *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. *Farmers Insurance Group v. SAIF*, 301 Or 612, 619 (1986).

Here, the ALJ's July 22, 1998 order was not expressly abated, stayed or withdrawn. Rather, it was expressly "amended" by the July 23, 1998 order, which corrected the ALJ's July 22, 1998 order by specifying the percentage of the penalty awarded. In all other respects, the July 23, 1998 order was identical to the July 22, 1998 order, including the fact that the appeal rights continued to run from the date of the July 22, 1998 order.

The insurer's July 30, 1998 request for Board review stated that it requested review of the ALJ's July 22, 1998 order, without mention of the July 23, 1998 amended order. Nevertheless, because the ALJ's July 23, 1998 order amended the July 22, 1998 order, we interpret the insurer's request as an appeal of the ALJ's July 22, 1998 order, as amended by the July 23, 1998 order. *See Rebecca C. Cole*, 49 Van Natta 153 (1997); *Terry L. Starnes*, 48 Van Natta 790, 791 n. 1 (1996); *Michael A. Ferdinand*, 44 Van Natta 1167, 1168 (1992). Inasmuch as the insurer's request was mailed to the Board within 30 days of the issuance of the ALJ's July 22, 1998 order (with copies timely provided to the other parties), we hold that we have jurisdiction to consider this matter. *See* ORS 656.289(3); ORS 656.295(2); *Terry L. Starnes*, 48 Van Natta at 791, n. 1 (1996). Accordingly, claimant's motion to dismiss is denied.

Penalties

The ALJ assessed a penalty pursuant to ORS 656.262(11)(a), finding that the insurer untimely paid medical bills submitted by Dr. Kolilis, Ph.D., for psychotherapy related to claimant's compensable PTSD. Specifically, the ALJ inferred from Dr. Kolilis' February 20, 1998 statement of services that Dr. Kolilis had promptly sent his bills to the insurer, but it did not pay some of those bills until more than 45 days after their receipt.

On review, claimant agrees with the ALJ's reasoning and contends that the untimely payment of Dr. Kolilis' billings entitles him to a penalty assessment. The insurer contends that claimant failed to establish when it received Dr. Kolilis' billings. Consequently, the insurer asserts that a penalty for untimely payment of the bills is not warranted. We agree with the insurer.

Carriers are required to "pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(1) and (2) and clearly shows that the treatment is related to the accepted compensable injury or disease." *Former* OAR 436-009-0030(2) (Admin. Order Nos. 96-069, eff. 1/1/97, and 97-053, eff. 7/1/97); OAR 436-009-0003(1). Thus, timely payment is due within 45 days of the *receipt* of a medical bill that meets certain requirements. We need not decide whether Dr. Kolilis' medical bills met the "proper form" requirements of *former* OAR 436-009-0010(1) and (2)[1] because the record fails to establish when the insurer received medical billings from Dr. Kolilis. Thus, we are unable to determine that the payments were untimely.

The ALJ and claimant rely on Dr. Kolilis' February 20, 1998 statement of services, which contained a notation from Dr. Kolilis that "payments were 5 months late. Still has a balance of $96." (Ex. 51-2). We find this reliance misplaced.

Although the statement of services shows the dates services were provided, it does not indicate when the insurer received billings for those services, or even when such billings were mailed. (*Id.*). Furthermore, it is apparent that Dr. Kolilis' comment that the "payments were 5 months late" referred to the date the services were rendered rather than the date the insurer received the billings, *e.g.*, the oldest service date is listed as "06/09/97," with the insurance payment for that service date listed as "11/08/97," which is five months from the service date. (*Id.*). In addition, the remaining record contains no indication of when Dr. Kolilis' billings were either mailed to or received by the insurer.

Moreover, because claimant has failed to establish when Dr. Kolilis' billings were mailed (*e.g.*, certificate of service, postal receipt), he cannot take advantage of the presumption of receipt under ORS 40.135(1)(q). *See Edward J. Demille*, 47 Van Natta 91 (1995); *Carol M. Cote-Williams*, 44 Van Natta 367, 369 (1992). Consequently, the record does not establish when the insurer received Dr. Kolilis' billings. *See Edward J. Demille*, 47 Van Natta at 93; *Bruce Hardee*, 46 Van Natta 2261 (1994). Thus, we are unable to determine whether the insurer's payments were untimely.

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[1] We note that billings not submitted in the proper form may be returned to the medical provider for correction and resubmission. *Former* OAR 436-009-0030(2). However, "[i]f an insurer returns such billings, it must be documented and done within 20 days of receipt of the bill." *Id.* In addition to asserting that claimant did not establish when it received the medical bills in question, the insurer also asserts that there was no proof those bills were submitted in the "proper form." Because we find that claimant failed to establish when the insurer received Dr. Kolilis' bills, we need not determine whether those bills were in the proper form or which party has the burden of proving whether or not bills are in the proper form.

Accordingly, no penalty can be assessed for the insurer's alleged failure to timely process those billings. Therefore, we reverse that portion of the ALJ's order that awarded a penalty for the insurer's allegedly untimely payment for medical services rendered by Dr. Kolilis.

Attorney Fees

The ALJ found that the 1997 amendments to ORS 656.386(1) did not apply to claimant's claim. The ALJ further determined that claimant did not establish a "denied claim" under *former* ORS 656.386(1) and, thus, was not entitled to an assessed attorney fee under that statute. Nevertheless, the ALJ determined that claimant was entitled to an assessed attorney fee under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation due to its failure to timely accept or deny claimant's PTSD claim. Consequently, the ALJ awarded claimant's attorney an assessed fee of $3,500 under ORS 656.382(1). Under the facts of this case, we find that claimant is not entitled to an attorney fee under either ORS 656.382(1) or ORS 656.386(1).

The award of attorney fees in workers' compensation matters is governed by statute. *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Unless specifically authorized by statute, the Board has no authority to award attorney fees. *Id.*

ORS 656.382(1) provides that, if a carrier "unreasonably resists the payment of compensation," it shall be liable for a reasonable attorney fee. Based on such language, even if a carrier does not timely accept a claim, there is no unreasonable resistance to payment of compensation if it paid all compensation; therefore, no attorney fee is available under ORS 656.382(1). *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993).

Here, there is no persuasive evidence that the insurer failed to pay any compensation. The only basis for claimant's argument that the insurer unreasonably resisted payment of compensation is his contention that some of Dr. Kolilis' medical bills were paid late or unpaid. But, as discussed above, because claimant failed to establish when the insurer received Dr. Kolilis' medical bills, we cannot determine when those bills became due. Therefore, we are unable to determine whether the insurer failed to timely pay those medical bills. It follows that, since there is no persuasive evidence that the insurer failed to pay compensation, including medical bills, there is no unreasonable resistance to payment of compensation. Therefore, there is no basis for an attorney fee under ORS 656.382(1). *Condon*, 119 Or App at 196; *Aetna Casualty Co. v. Jackson*, 108 Or App 253, 257 (1991).

That brings us to the issue of whether claimant is entitled to an attorney fee under ORS 656.386(1). As a preliminary matter, we note that claimant contends that the insurer is barred from arguing against an award of an attorney fee under ORS 656.386(1) because, in violation of OAR 438-006-0036,[2] it failed to file a "Response to Issues" in response to claimant's October 1, 1997 supplemental request for hearing. In that supplemental request, claimant raised issues of a partial "de facto" denial of PTSD, compensability of that condition, and attorney fees.

Here, no hearing was held. Instead, the parties agreed to submit the matter on the written record and closing arguments. While we will not consider an issue raised for the first time in closing argument, even when an in-person hearing is not held,[3] the insurer did not raise a "new issue" in closing argument or on review. Instead, the attorney fee issue was raised by claimant himself in his October 1, 1997 supplemental request for hearing. Thus, the issue of entitlement to attorney fees was properly before the ALJ and the Board.

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[2] OAR 438-006-0036 provides, in relevant part:

"Not later than 15 days after receiving the listing of issues and other information required by OAR 436-006-0031, a party defending against a request for hearing shall, on a form prescribed by the Board, file and simultaneously mail copies to all other parties a response specifying the respondent's position on the issues raised and relief requested and any additional issues raised and relief requested by the respondent."

[3] *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995) ("We have consistently held that we will not consider an issue raised for the first time during closing argument." (citations omitted)); *see also Felipe A. Rocha*, 44 Van Natta 797 (1992); *Leslie Thomas*, 44 Van Natta 200 (1992); *Karel L. Nelson*, 42 Van Natta 1206 (1990). In addition, we have held that, where the parties elect to present their case based on the written record, we consider it appropriate to interpret the presentation of that record as the "hearing." In this way, the closing arguments (whether written or oral) will be treated in the same consistent manner, regardless of whether an "in-person" hearing was convened. *Cindy M. Penturf*, 50 Van Natta 1718, 1720 n.3 (1998).

Furthermore, claimant cites no legal support, and we find none, for his contention that an opposing party may not argue against an issue that is properly before the ALJ and the Board. The insurer did not concede that claimant was entitled to an attorney fee under ORS 656.386(1). So long as an issue is properly raised, the opposing party may present arguments against it. Accordingly, we do not find that the insurer is barred from arguing against an attorney fee award under ORS 656.386(1). Therefore, we proceed to the merits.

Pursuant to ORS 656.386(1), a claimant's counsel is entitled to an attorney fee "in such cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. Under the law in effect at the time of claimant's claim,[4] a "denied claim" was defined as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation."[5] *Former* ORS 656.386(1).

Although claimant does not dispute that *former* ORS 656.386(1) applies to his claim, he argues that he is entitled to an assessed attorney fee under that statute. Specifically, claimant asserts that the insurer's conduct indicated it was treating the PTSD condition as a denied claim and its actions and omissions can be construed as an express denial. We disagree.

In applying *former* ORS 656.386(1), the court has required an explicit response from the carrier that can be interpreted as a refusal to pay on the express ground that the condition for which compensation is claimed is not compensable before a carrier's actions can be deemed to constitute an express denial of compensation under that statute. *See Galbraith v. L.A. Pottsratz Const.*, 152 Or App 790 (1998); *Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997). Both *Galbraith* and *Bowman* applied *former* ORS 656.386(1) and determined that the carriers' responses to the claimants' hearing requests constituted express denials of compensation under that statute.

In *Bowman*, the claimant requested a hearing on a "de facto" denial of two conditions. The employer had paid the claimant's medical bills for those conditions on a prior, accepted claim, but it had not accepted the conditions. In response to the hearing request, the employer filed a check-the-box response that said that claimant had not sustained a work-related injury or disease. The employer later accepted the claim for those conditions but resisted an award of attorney fees under *former* ORS 656.386(1) for one of the conditions, on the ground that it had not expressly denied that condition.

The court rejected the employer's argument that there was no "denied claim" as that term was defined under *former* ORS 656.386(1) because it had not refused to pay compensation for the disputed condition. The court explained:

> "Although employer had not refused to pay compensation up to the time claimant put the compensability of the conditions at issue, its notation on the response form was an express denial of the conditions on the ground that they were not related to the employment. It carried with it an implicit refusal to pay compensation in the future. * * * Although the check-the-box notation did not satisfy the requirements for a denial set forth in ORS 656.262(9), it nonetheless unequivocally expressed employer's denial of compensability." *Bowman*, 148 Or App at 295.

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[4] ORS 656.386(1) was amended by the 1997 Legislature, but the revisions that went into effect on July 25, 1997 were not made retroactive and are therefore not applicable to this case. *See Stephenson v. Meyer*, 150 Or App 300, 304 n.3 (1997) (noting that the 1997 revisions to ORS 656.386(1) were not made retroactive). In addition, although *amended* ORS 656.386(1) applies prospectively to all claims for compensation, aggravation or new medical conditions presented on or after the statute's July 25, 1997 effective date, regardless of the date of injury, that does not affect the applicability of *amended* ORS 656.386(1) under the facts of this case. *Chancey F. James*, 50 Van Natta 1370 (1998). In this regard, claimant presented his claim on June 26, 1997, when claimant's counsel sought amendment of the notice of acceptance to include PTSD. Thus, claimant's claim was made *before* the July 25, 1997 effective date of *amended* ORS 656.386(1). Therefore, *former* ORS 656.386(1) applies under the facts of this case.

[5] Under *amended* ORS 656.386(1)(b), a "denied claim" also includes: (1) a claim for a condition omitted from the notice of acceptance, made pursuant to ORS 656.262(6)(d), to which the carrier does not respond within 30 days; and (2) a claim for an aggravation or new medical condition made pursuant to ORS 656.262(7)(a), to which the carrier does not respond within 90 days. *Amended* ORS 656.386(1)(b)(B) and (C).

Subsequently, the court applied the same reasoning in *Galbraith*, where the claimant requested a hearing on a "de facto" denial of a consequential condition for which the carrier had paid the medical expenses under a prior accepted claim. In its response to the claimant's hearing request, the carrier indicated that the "claimant is entitled to no relief." At hearing, the carrier accepted the claim, but contended that the claimant was not entitled to an attorney fee under *former* ORS 656.386(1) because it had not expressly denied the claimant's claim. The court found that, as in *Bowman*, the carrier's notation that the "claimant is entitled to no relief" carried with it an implicit refusal to pay compensation in the future and constituted a "denied claim under *former* ORS 656.386(1). *Galbraith*, 152 Or App at 795; *see also Joni M. Varah*, 50 Van Natta 1124, *on recon* 50 Van Natta 1360 (1998) (relying on holdings in *Galbraith* and *Bowman*, Board held that the carrier's written acceptance of "resolved" condition constituted express denial of claim on basis that condition would not give rise to entitlement to any compensation).

Here, the insurer apparently paid claimant's medical expenses regarding his PTSD condition under the initial claim. But, as the court explained in *Bowman* and *Galbraith*, that is not determinative in deciding whether a carrier denied a claim within the meaning of *former* ORS 656.386(1). On the other hand, unlike the carriers in *Bowman* and *Galbraith*, the insurer here did *not* make any express denial of compensation of the PTSD condition. To the contrary, in its May 21, 1997 "Response to Issues" regarding claimant's April 8, 1997 hearing request, the insurer explicitly denied "that the [insurer] has denied the compensability of this claim" and stated that "no conditions have been denied. The claim is accepted. All benefits have been paid." Although the insurer did not issue a "Response to Issues" regarding claimant's October 1, 1997 supplemental hearing request, neither did it submit anything to alter its prior statement that it had not denied compensability of the claim.

On this record, we are not persuaded that the insurer refused to pay on the express ground that the PTSD condition was not compensable or otherwise did not give rise to an entitlement to any compensation. Accordingly, claimant is not entitled to an attorney fee under *former* ORS 656.386(1).

ORDER

The ALJ's order dated July 22, 1998, as amended on July 23, 1998, is reversed in part and affirmed in part. The ALJ's penalty and attorney fee awards are reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
GERARDO ALANIS, Claimant
WCB Case No. 97-06529
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by the Board *en banc*.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that: (1) calculated claimant's temporary total disability (TTD) rate as $270.00 per week; and (2) awarded temporary partial disability (TPD) payable at the TTD rate beginning June 20, 1997. Claimant cross-requests review of that portion of the ALJ's order that declined to award penalties for the employer's allegedly unreasonable refusal to pay temporary disability after June 19, 1997. On review, the issues are entitlement to temporary disability, rate of temporary disability, and penalties. We modify in part and affirm in part.

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 in the findings of ultimate fact.

For the purposes of this proceeding only, claimant does not contest the employer's position that, since May 21, 1997, claimant has not been legally authorized to work in the United States, *i.e.*, an "illegal alien."

The employer, a temporary service provider, employed claimant as a reforestation laborer on a temporary basis. During his employment with the employer, claimant was assigned to Piatkoff Forest Service (Piatkoff). (Exs. AA, C, 1).

From September 2, 1996 through November 29, 1996, claimant did pruning work in Astoria. (Ex. AA). This pruning work required using shears to trim branches from trees. (Tr. 12, 18). It did not require cutting down trees. (Tr. 18). Claimant was paid $8 per hour and generally worked five days per week with either Saturdays and Sundays or Sundays and Mondays off. (Ex. AA). From September 2, 1996 through November 29, 1996, claimant worked a total of 339 hours and earned gross wages of $2,712.00. (Ex. 2D). There were gaps in work of two weeks from September 16, 1996 through September 29, 1996, and one week from November 10, 1996 through November 17, 1996. (Ex. AA-1, -2, -4, -5).

After November 29, 1996, there was a gap in claimant's work of over five months, with claimant next working for the employer on May 12, 1997. (Exs. AA-5, C). Claimant was again assigned to Piatkoff and worked thinning trees, which was done with a chainsaw and required falling trees up to ten inches in diameter. (Tr. 12, 18, Ex. 1). Claimant was paid $10 per hour for this work. He worked Monday, May 12, 1997, through Saturday, May 17, 1997, for a total of 38 hours. (Ex. C). He had Sunday, May 18, 1997, off. On May 19, 1997 and May 20, 1997, he worked eight hours per day. From May 12, 1997 through May 20, 1997, claimant worked 54 hours and earned gross wages of $540.00. (Ex. 2D).

At the end of the work day on May 20, 1997, claimant sustained a compensable left leg fracture. (Exs. 1, 10).

Claimant was released from work from May 21, 1997 until June 10, 1997, at which time Dr. Yamanaka, claimant's attending physician, approved a modified work position and released him for modified work. (Exs. 3, 4, 14). In its request for Dr. Yamanaka's approval of the proposed modified job, the employer notified him of the physical tasks to be performed by claimant in that job, which consisted of collating employment applications with the ability to elevate his leg and take breaks as desired. (Exs. 4-3, -4).

The employer has a written policy of offering modified work to injured workers. (Ex. 17).

The social security number and alien registration number claimant provided to the employer were valid numbers but they belong to other persons, not claimant. (Exs. 11, 12, 13).

On June 17, 1997, the employer notified claimant that it had become aware that the social security number claimant provided was not issued to him. (Ex. 4). The employer terminated claimant for providing it with false documentation, which was a violation of the employer's work rules. (Ex. 4, Tr. 21). With its termination notice, the employer included copies of Dr. Yamanaka's modified work release, the modified job description approved by Dr. Yamanaka, and a modified work offer that outlined the hours, wages, report date, and location. The hours of the modified work offer were listed as 8:00 a.m. to 4:30 p.m., Monday through Friday, with a half hour unpaid lunch, and Saturdays and Sundays off. The wage listed was $325.20 per week. (Ex. 4-2). The employer notified claimant that, but for his termination, the modified job would have been offered to him. (Ex. 4-1).

The employer paid claimant TTD from May 20, 1997 through June 19, 1997. (Ex. D, Tr. 7). It paid claimant no temporary disability benefits after June 19, 1997. Claimant has earned no wages since he left work on May 20, 1997, the date of the compensable injury. At the time of the hearing, claimant had not been released to regular work.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The ALJ found that under either ORS 656.325(5)(b) or (c),[1] the employer was required to cease payments under ORS 656.210[2] and commence payments under ORS 656.212.[3] In calculating claimant's rate of temporary disability benefits, the ALJ concluded that OAR 436-060-0030(7)[4] exceeded the Director's rule making authority and, therefore, was invalid. Instead, the ALJ found that claimant's TPD benefits were to be paid at the TTD rate, which he calculated as $270.00 per week pursuant to OAR 436-060-0025(5)(a)(B)(ii). While we agree that the employer was required to cease payments under ORS 656.210 and commence payments under ORS 656.212, we disagree with the ALJ's conclusions regarding the calculation of claimant's TPD rate and the validity of OAR 436-060-0030(7).

Here, for the purposes of this proceeding only, claimant does not contest the employer's position that, for all periods for which temporary disability is sought, he has been a person present in the

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[1] ORS 656.325(5) provides, in relevant part:

"(5) Notwithstanding ORS 656.268:

"* * * * *

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

"(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job whether or not such a job is available."

[2] ORS 656.210 pertains to temporary total disability benefits.

[3] ORS 656.212 pertains to temporary partial disability benefits.

[4] OAR 436-060-0030(7) pertains to the payment of TPD for illegal aliens when they are released to modified work by their attending physicians and provides:

"(7) Pursuant to ORS 656.325(5)(c), 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 employment when the attending physician approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

"(a) 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);

"(b) The attending physician has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

"(c) The attending physician agrees the employment appears to be within the worker's capabilities." WCD Admin. Order No. 96-070 (eff. 11/27/96).

United States in violation of federal immigration laws, *i.e.*, an "illegal alien." Claimant was terminated for violation of work rules when it was discovered that he provided the employer with false documentation regarding his social security number. (Ex. 4, Tr. 21). The employer has a written policy of offering modified work to injured workers. (Ex. 17). Furthermore, the employer notified claimant's attending physician of the physical tasks that claimant would perform in a proposed modified job offer, and the attending physician agreed that the employment was within claimant's capabilities. (Exs. 3, 4, 14).

The parties agree that, under the facts of this case, both ORS 656.325(5)(b) and (c) apply, although their arguments focus on ORS 656.325(5)(c). Thus, there is no dispute that, once the attending physician approved the modified job, claimant was no longer entitled to TTD, but instead was entitled to TPD. The parties' dispute focuses on the rate at which the TPD should be paid. Claimant argues that, because he had no actual earnings after being released to modified work, pursuant to ORS 656.325(5)(c) and 656.212(2), his TPD should be paid at the TTD rate, as the ALJ concluded. Claimant also argues that the ALJ was correct in determining that his average weekly wage at injury was $405.00, resulting in a TTD rate of $270.00 per week. The employer argues that the TPD rate under ORS 656.325(5)(c) and 656.212(2) should be zero because the modified work would have paid the same wage as claimant's regular work.

While we agree that under either ORS 656.325(5)(b) or (c) once the attending physician approved the modified job, claimant was entitled to TPD, not TTD, we find that ORS 656.325(5)(c) applies to the facts of this case. Although claimant was terminated pursuant to ORS 656.325(5)(b) for violation of work rules, the fact remains that he is an "illegal alien." Because ORS 656.325(5)(c) is a particular provision regarding payment of TPD to "illegal aliens," it controls over ORS 656.325(5)(b), a more general statutory provision dealing with employees terminated for violation of work rules. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993).

In *Alfredo R. Hernandez*, 51 Van Natta 71 (1999), a decision issued after the ALJ's order, we determined the method of calculating TPD benefits for illegal aliens under ORS 656.325(5)(c) and ORS 656.212.[5] There, the claimant was an illegal alien who sustained a compensable injury. The claimant was initially taken off work for a period of time by his attending physician, and the carrier paid him TTD during that period. The attending physician later approved modified employment that was available at the same hours and wages as the job at injury, but was only available for about a month. Thereafter, modified work was not available.

We determined that the text and context of ORS 656.325(5)(c) unambiguously authorizes the carrier to stop paying TTD and to commence the payment of TPD when the physician approves employment in a modified job, the only precondition required by the legislature. We found that the employer need not make a showing that a job would have been actually offered to the worker, or that it had a written policy of offering modified work to injured workers. Thus, when the attending physician approved the modified job, the carrier was authorized to cease payments pursuant to ORS 656.210 (TTD) and commence payments pursuant to ORS 656.212 (TPD).

Turning to the calculation of the claimant's TPD under ORS 656.325(5)(c), we noted a seeming inconsistency between the statutory provisions in ORS 656.212(2), which would support payment of TPD at the full TTD rate, and ORS 656.325(5)(c), which would support payment of TPD at a lesser amount (even zero) if the attending physician approved modified work at a job that is nevertheless unavailable. We resolved this potential conflict by reasoning that, because ORS 656.325(5)(c) is a particular provision regarding payment of TPD to "illegal aliens," to the extent that there was any inconsistency between that provision and ORS 656.212, a general statutory provision, ORS 656.325(5)(c) controlled. ORS 174.020; *PGE*, 317 Or at 610-11. Furthermore, considering the specific provision of

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[5] ORS 656.212 provides:

"When the disability is or becomes partial only and is temporary in character:

"(1) No disability payment is recoverable for temporary disability during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury. If the worker leaves work or loses wages on the day of the injury due to the injury, that day shall be considered the first day of the three-day period.

"(2) The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive for an aggregate period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of wages bears to the wage used to calculate temporary total disability pursuant to ORS 656.210."

ORS 656.325(5)(c) ("whether or not such a job is available"), we determined that the calculation of TPD under ORS 656.212(2) did not require *actual* lost wages from modified employment in the case of an injured worker who is in this country in violation of federal immigration laws. We found that any other interpretation would render the particular provisions of ORS 656.325(5)(c) meaningless.

In light of the legislature's clear intent to reduce payments of temporary disability to persons present in the United States in violation of federal law from TTD to TPD, we gave effect to both ORS 656.325(5)(c) and 656.212 by concluding that the wage for an "approved," but "non-offered," modified job must be included in the calculation of an illegal alien's TPD. We also found that OAR 436-060-0030(7) was consistent with our analysis of the statutory scheme and provided a reasonable method, consistent with ORS 656.325(5)(c) and 656.212, by which the rate of TPD payments can be calculated *whether or not the modified job is available.* Accordingly, we found OAR 436-060-0030(7) valid.

Finally, applying the facts of that case to the law, we determined that the claimant's TPD rate was zero because the modified job approved by the attending physician, whether or not it was available, was for the same hours and wages as the job at injury. Regarding the limited duration the modified work was available, we found that, because ORS 656.325(5)(c) provides for payment of TPD regardless of job availability, there was no need to distinguish between the period when the claimant could have performed work for the employer and the subsequent period when the employer's modified job was no longer available.

Here, the parties dispute both the amount of claimant's average weekly wage at the time of injury and whether the employer's modified job offer approved by the attending physician was for the same hours and wages as the job at injury. Thus, in order to determine claimant's TPD rate, we must first determine his average weekly wage at injury.

The rate of temporary disability benefits is based on a worker's wage at the time of injury. ORS 656.210(1), (2)(b)(A). For workers whose remuneration is not based solely on daily or weekly wages, the Director of the Department of Consumer and Business Services (Director) may prescribe rules for establishing the worker's weekly wage. ORS 656.210(2)(c).

At the time of claimant's injury on May 20, 1997, OAR 436-060-0025(5)[6] applied to determine the average weekly wage for workers, like claimant, who were employed on other than a daily or weekly

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[6] OAR 436-060-0025(5) provides, in part:

"(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * *

"(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

"(A) Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in written form.

"(B)(i) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due only to a pay increase or decrease, insurers shall use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this subsection, multiplied by the wage at injury to determined the worker's current average weekly earnings.

"(ii) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, insurers shall average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

"(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

"(b) Workers employed through a temporary service provider on a 'temporary basis,' or a worker-leasing company as defined in OAR 436-050, shall have their weekly wage determined by the method provided in subsection (a) of this rule. However, each job assignment shall not be considered a new wage earning agreement." WCD Admin. Order No. 96-070 (eff. 11/27/96).

basis. While the employer and claimant agree that OAR 436-060-0025(5)(b) applies to this case because claimant was employed as a temporary worker through a temporary service provider, they reach different results in applying that rule. The employer contends that OAR 436-060-0025(5)(b) eliminates the application of OAR 436-060-0025(5)(a)(B), which deals with the calculation of temporary disability rates where there is a change in the wage earning agreement. Claimant counters that OAR 436-060-0025(5)(b) only establishes that each job assignment for a temporary service worker is not automatically to be considered a new wage earning agreement, but the circumstances of a case can establish a new wage earning agreement, which would be calculated under one of the provisions of OAR 436-060-0025(5)(a)(B). Claimant contends that the circumstances of his case establish a new wage earning agreement. We agree with claimant's analysis.

OAR 436-060-0025(5)(b) provides:

> "Workers employed through a temporary service provider on a "temporary basis," or a worker-leasing company as defined in OAR 436-050, shall have their weekly wage determined by the method provided in subsection (a) of this rule. However, each job assignment shall not be considered a new wage earning agreement."

Rules are to be interpreted in the same manner as statutes. That is, we are "simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted * * *." ORS 174.010. In interpreting a rule, we assume that the agency's choice of words is purposeful; therefore, we should not disregard that choice. *See Martin v. City of Albany*, 320 Or 175, 181 (1994) (interpreting a statute, the Court stated that it does "not lightly disregard the legislature's choice of verb tense, because [it assumes] that the legislature's choice is purposeful"). Moreover, the words of a rule are to have their common, ordinary meaning unless there is a clear indication that some other meaning was intended. *Welliver Welding Works v. Farmen*, 133 Or App 203, 208 (1995) (applying this reasoning to the interpretation of a statute).

The employer essentially argues that the last sentence of OAR 436-060-0025(5)(b) eliminates the possibility that a temporary worker employed through a temporary service provider could have a change in a wage earning agreement and, therefore, the provisions of OAR 436-060-0025(5)(a)(B) would never apply to a temporary worker. But such an interpretation would restrict that portion of OAR 436-060-0025(5)(b) that provides that temporary workers "shall have their weekly wage determined by the method provided in *subsection (a)* of this rule" to include only subsection (a)(A) and eliminate subsection (a)(B). (Emphasis added). Such a restriction disregards the Director's choice of words. If the Director had intended that temporary workers have their temporary disability calculated only pursuant to OAR 436-060-0025(5)(a)(A), he would have indicated such a restriction. Instead, the Director specifically stated that temporary workers provided through a temporary service provider "shall have their weekly wage determined by the method provided in subsection (a)," which includes both subsections (a)(A) and (a)(B).

Furthermore, the last sentence of OAR 436-060-0025(5)(b) ("[h]owever, each job assignment shall not be considered a new wage earning agreement") is consistent with this interpretation. In this regard, although *each* job assignment is not to be considered a new wage earning agreement, a particular job assignment that sufficiently changes the wage earning agreement may be considered a new wage earning agreement to which one of the provisions of OAR 436-060-0025(5)(a)(B) would apply. Under this interpretation all provisions of OAR 436-060-0025(5)(b) are rendered consistent, without omitting or inserting any terms.

Here, we agree with the ALJ that claimant's job assignment in May 1997 represented a change in the wage earning agreement due to a significant change in job duties. Specifically, claimant's job assignment in 1996 involved pruning trees, which required the use of shears to remove branches from trees, and paid $8.00 per hour. In contrast, claimant's job assignment in May 1997 involved thinning trees, which required the use of a chain saw to remove trees up to ten inches in diameter, and paid $10.00 per hour. We find this change in job duties sufficient to represent a change in the wage earning agreement. Therefore, we find that OAR 436-060-0025(5)(a)(B)(ii) applies to determine claimant's average weekly wage.

OAR 436-060-0025(5)(a)(B)(ii) provides:

"(ii) Where there has been a change in the wage earning agreement during the 52 weeks prior to the date of injury due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, insurers shall average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A)."

Claimant worked less than four weeks under the most recent wage earning agreement. (Ex. C). Under OAR 436-060-0025(5)(a)(A), for workers employed less than four weeks, the carrier "shall use the intent of the wage earning agreement as confirmed by the employer and the worker."

We find that the 801 form and the May 1997 time sheet report establish the intent of the wage earning agreement. (Exs. C, 1). The 801 form lists the job at injury as operating a chainsaw for a thinning assignment, with a shift of eight hours, five days per week, and wages of $10 per hour. (Ex. 1). The May 1997 time sheet report confirms the 801 form. Prior to being injured, claimant worked the same hours as the rest of the crew. (Ex. C). The crew worked 38 hours over six days the first week and 40 hours over five days the second week. (*Id.*). Claimant was injured at the end of his second day of work in the second week. (*Id.*). On this record, we find that the intent of the parties was for claimant to work an eight hour shift, five days per week, at wages of $10 per hour. Thus, claimant's average weekly wage was $400.00. (8 x 5 x $10 = $400).

The employer argues that its modified work offer would have paid claimant the same wage as his regular job. We disagree.

Because the person who handled the employer's workers' compensation matters was on leave, Mr. Johnston, the employer's safety manager, testified on behalf of the employer. (Tr. 20). Mr. Johnston testified that the wage paid an injured worker for modified work would be the same as the worker earned at his regular work. (Tr. 28). But he also testified that the modified job that would have been offered to claimant paid $325.20 per week, as the written offer indicated. (Tr. 29, Ex. 4-2). Mr. Johnston was not sure whether wages offered for modified work would change if it was later discovered that the injured worker's regular wage was different from the modified work wage. (Tr. 34). Finally, Mr. Johnston agreed that the modified work wage would increase under those circumstances. (*Id.*). Given Mr. Johnston's apparent confusion about the payment of modified wages, we find more persuasive the modified wage listed on the employer's written modified job "offer." (Ex. 4-2). Thus, we find that the modified work that the employer would have offered claimant (if he had been able to be legally employed within the United States and had not been terminated for providing the employer false documentation) paid $325.20 per week. (Ex. 4-2).

The employer argues that it did not matter what modified wage it offered claimant because any wage offer was only theoretical, since claimant could not legally work in the United States and any loss of earnings was due to that fact, not his compensable injury. Therefore, the employer asserts, claimant's TPD should be calculated as zero. In *Hernandez*, we found that, in enacting ORS 656.325(5)(c), the legislature could have provided that illegal aliens are not entitled to TPD, but it did not do so. Instead, the legislature specifically provided that, once the attending physician released an illegal alien to perform modified work, the employer was to stop payment of TTD and begin payment of TPD. As explained above, in order to give effect to both ORS 656.325(5)(c) and 656.212, we concluded that the wage for an "approved," but "non-offered," modified job must be included in the calculation of an illegal alien's TPD. Furthermore, the Director's rule regarding calculation of TPD for illegal aliens is consistent with this reasoning, *i.e.*, it calculates TPD based on a "modified job offer" for the "theoretical" job. OAR 436-060-0030(7). Thus, contrary to the employer's argument, the modified wage does matter in determining claimant's TPD rate.

Applying the formula in OAR 436-060-0030(2),[7] results in a TPD rate of $49.87 per week. Claimant argues that, pursuant to OAR 436-060-0030(7)(a) and 436-060-0030(2)(a), because the employer

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[7] OAR 436-060-0030(2) provides:

"(2) The amount of temporary partial disability compensation due a worker shall be determined by:

"(a) Subtracting post-injury wage earnings by the worker from any kind of work from

did not provide the duration of the proposed modified work offer, "it would be entitled to a wage offset at the rate of $325.20 per week, for zero weeks[, * * *] which is no reduction at all." Responsent's/Cross-Appellant's Brief, pages 6-7. Thus, claimant essentially argues that failure to provide the duration of the modified job results in a TPD rate equal to the TTD rate. We disagree.

As shown in footnote 8, it is not necessary to know the duration of the modified work to determine the weekly TPD rate. In addition, neither OAR 436-060-0030(7)(a) nor 436-060-0030(2)(a) require that the proposed modified job offer provide the duration of that job. OAR 436-060-0030(7)(a) only provides for written documentation of the hours available to work and the wages that would have been paid in order to determine the amount of TPD under OAR 436-060-0030(2).[8] Here, the employer provided that information. (Ex. 4-2). Furthermore, we rejected a similar argument in *Hernandez*, where we determined that, because ORS 656.325(5)(c) provides for payment of TPD regardless of job availability, there was no need to distinguish between the period when the modified work could have been performed and the subsequent period when the modified job was no longer available. All that was necessary was the hours available to work and the wages that would have been paid for the proposed modified work. That information was provided here. Therefore, we reject claimant's argument.

Thus, claimant is entitled to TPD of $49.87 per week from June 20, 1997,[9] until such benefits may be terminated under law. ORS 656.325(5)(c).

Penalties

We adopt the ALJ's reasoning and conclusions on this issue. Our recent decision in *Hernandez* is the first case interpreting ORS 656.325(5)(c). Therefore, we find that the employer had a reasonable doubt as to its liability to pay TPD under the circumstances of this case.

Attorney Fees

Because we have reduced claimant's TPD rate, claimant's attorney is not entitled to a fee under ORS 656.382(2).

ORDER

The ALJ's order dated July 13, 1998 is modified in part and affirmed in part. In lieu of the ALJ's award of TPD at the rate of $270.00 per week, the employer is ordered to pay an award of TPD at the rate of $49.87 per week commencing June 20, 1997, until such benefits may be terminated under law. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed.

"(b) The wage used to compute the rate of compensation at the time of injury; then

"(c) Dividing the difference by the wage earnings used in subsection (b) to arrive at the percentage of loss of earning power; then

"(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of earning power in subsection (c)."

[Claimant's TTD rate is $266.68 per week ($400.00 x .6667 = $266.68). ORS 656.210(1)].

(a) & (b): $400.00 - $325.20 = $74.80
(c): $74.80 ÷ $400.00 = .187
(d): $266.68 x .187 = $49.87 = Claimant's TPD rate per week.

[8] We note that the employer asserts that this provision of OAR 436-060-0030 is invalid because it goes beyond ORS 656.325(5)(c), which does not require written documentation of the hours or wages that the proposed modified work would offer. As noted above, in *Hernandez*, we found that OAR 436-060-0030 was valid and provided a reasonable means to determine the TPD rate required under ORS 656.325(5)(c).

[9] We note that the employer paid TTD through June 19, 1997. The parties do not dispute the payment of temporary disability benefits prior to June 20, 1997. Their dispute focuses solely on the temporary disability benefits due after June 19, 1997. Therefore, we find that the TPD rate of $49.87 begins as of June 20, 1997.

Board Member Biehl specially concurring.

For the reasons expressed in my dissenting opinion in *Alfredo R. Hernandez*, 51 Van Natta 71 (1999), I would have agreed with the ALJ's conclusion that claimant's TPD should be paid at his TTD rate. Nonetheless, because I am compelled to follow the *Hernandez* holding by the doctrine of *stare decisis*, I submit this special concurrence in joining the majority decision.

February 12, 1999 Cite as 51 Van Natta 278 (1999)

In the Matter of the Compensation of
JOSEPH A. GERBER, Claimant
WCB Case Nos. 97-07564 & 97-06786
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by the Board *en banc*.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) set aside its "de facto" denial of claimant's C5-6 disc derangement/disruption; and (2) found that claimant's neck injury claim was prematurely closed. On review, the issues are compensability and premature closure. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following summary of relevant facts regarding the premature closure issue.[1]

On November 21, 1996, claimant sustained a compensable injury when he slipped and fell. The Emergency Room doctor diagnosed a "left shoulder contusion," which is the condition the insurer accepted on December 4, 1996. (Ex. 5). Subsequently, claimant began treating with Dr. Matteri, orthopedist, who suspected that claimant's shoulder and arm pain was radiating from his neck. Cervical x-rays were obtained, but were not helpful, and an MRI of claimant's cervical spine was normal. Claimant underwent physical therapy.

On March 20, 1997, Dr. Matteri examined claimant and found him neurologically intact, with normal cervical and shoulder ranges of motion. Dr. Matteri declared claimant medically stationary and able to return to work. (Ex. 12).

An April 2, 1997 Determination Order closed claimant's claim, declaring him medically stationary as of March 20, 1997, and awarding temporary disability compensation only. (Ex. 14). At claim closure, the only accepted condition was the left shoulder contusion condition. Claimant requested reconsideration and raised the issue of premature closure, among other issues.

On July 11, 1997, claimant underwent a medical arbiter's exam performed by Dr. Filarski, an orthopedist. (Ex. 24). Although Dr. Filarski found claimant's shoulder contusion "essentially resolved" and indicated no impairment for that condition, he suspected that claimant was experiencing C6-7 radiculopathy due to cervical disc pathology. Due to this cervical condition, Dr. Filarski found claimant not medically stationary.

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[1] We note two clarifications that are necessary regarding the exhibits listed by the ALJ as received into evidence at hearing. First, Exhibit 3A, the November 21, 1996 ambulance report, apparently was renumbered as Exhibit 2A in unrecorded discussions regarding the exhibits, although that exhibit remained numbered as "Exhibit 3A" in the record. *See* Tr. 1; Opinion and Order, page 1; May 28, 1998 Supplemental Exhibit List. Second, although the ALJ included "Exhibit 23" as among those received into evidence, there is no "Exhibit 23" in the record. On review, the parties have stipulated that "Exhibit 23 was a mistake and ignored at hearing." Thus, there was no "Exhibit 23" admitted into evidence.

An August 11, 1997 Order on Reconsideration affirmed the April 2, 1997 Determination Order in all respects, including finding claimant medically stationary as of March 20, 1997. (Ex. 27). Claimant requested a hearing, raising issues of compensability of the cervical condition and premature closure.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

Premature Closure

The ALJ found claimant's cervical condition compensable. The ALJ also determined that claimant's condition did not materially change between March 1997, the time Dr. Matteri declared claimant medically stationary, and the time of hearing. In addition, the ALJ found that claimant required curative treatment after claim closure. Thus, based on claimant's cervical condition, the ALJ inferred that claimant was not medically stationary at the time of claim closure. The insurer argues that the ALJ should not have considered claimant's cervical condition in deciding the premature closure issue. We agree.

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

In *James L. Mack*, 50 Van Natta 338 (1998), we held that under the current statutory scheme, as amended in 1997, a determination of whether a claim has been prematurely closed (because the worker was not medically stationary) must focus only on those conditions that were accepted at the time of claim closure. We further held that an evaluation of condition(s) accepted after claim closure must await the reopening and processing of the claim for the new condition(s). *Id.* We found support for our conclusion in several provisions of ORS 656.262(7)(c),[2] especially the statement that "[i]f a condition has been found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

We found further support for our conclusion in the provisions of ORS 656.262(7)(c) that provide for the carrier to "issue at claim closure an updated notice of acceptance that specifies which conditions are compensable" and provide that claim closure shall not be delayed due to an objection to the updated notice or an appeal of a denied condition. We found that these provisions also indicated that the focus at claim closure is on accepted conditions. Moreover, we noted that, if a condition is subsequently found compensable, the statute requires reopening for processing of the new condition. *See also Michael C. Reddin*, 50 Van Natta 1396 (1998).

Claimant argues that *Mack* is distinguishable on its facts. Specifically, claimant notes that *Mack* involved physical injuries caused by a work injury that were stationary at the time of claim closure and a consequential psychological condition that was not stationary at closure and was not accepted until after closure. Claimant contends that, because his cervical condition is not a consequential condition but rather a direct injury caused at the time of the original incident, the reasoning in *Mack* does not apply to his claim. In support of his contention, claimant argues that, in the context of a direct injury condition such as his, the Board should give greater weight to ORS 656.268(1), which states, in part, "claims shall not be closed if the worker's condition has not become medically stationary." We disagree.

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[2] ORS 656.262(7)(c) 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."

When interpreting statutory language, our task is to discern the intent of the legislature; this process begins with an examination of the text and context of the statutory provision. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). The context includes provisions of the same statute and other statutes relating to the same subject matter. *Id.* at 611. In examining context, we consider relevant rules of statutory construction, such as the statutory mandate that, "where there are several provisions or particulars, such construction is, if possible, to be adopted as will give effect to all." ORS 174.010. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. *PGE*, 317 Or at 611-12.

As noted above, we have examined the language of ORS 656.262(7)(c) and determined that the legislature intended that the determination of whether a claim has been prematurely closed is limited to those conditions that were accepted at the time of claim closure. Nothing in ORS 656.262(7)(c) indicates that the legislature intended that the provisions of that statute should only apply to *consequential* conditions found compensable after closure. To the contrary, there is no limitation on the type of "condition" ORS 656.262(7)(c) applies to, other than the condition must have "been found compensable after claim closure."

Furthermore, our interpretation of ORS 656.262(7)(c) renders both ORS 656.268(1) and ORS 656.262(7)(c) effective. In this regard, under ORS 656.262(7)(c), the determination of whether a claim has been prematurely closed is limited to those conditions that were accepted at the time of claim closure; however, because the carrier is required to open the claim for any conditions accepted after closure, any subsequently accepted conditions will necessarily be processed to closure, including the determination of medically stationary status. Thus, the mandate of ORS 656.268(1) will be met for each accepted condition.

To find otherwise and grant claimant's request to give greater weight to ORS 656.268(1) for direct injury conditions accepted after closure would result in a statutory construction that creates a conflict between ORS 656.268(1) and ORS 656.262(7)(c) and renders ORS 656.262(7)(c) ineffective. In this regard, if the medically stationary status of a condition found compensable after closure can relate back to the initial claim closure, the requirement under ORS 656.262(7)(c) to reopen a claim found compensable after claim closure is rendered ineffective, as is the provision that an objection to an updated notice of acceptance or an appeal of a denied condition shall not delay claim closure. In addition, claimant's interpretation limits application of ORS 656.262(7)(c) to consequential conditions, whereas the legislature provided for no such limitation. *See Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 83 (1980) (Court will avoid a statutory construction which creates a conflict between statutes or renders one statute ineffective). Therefore, after considering claimant's arguments regarding ORS 656.268(1), we continue to conclude that the legislature intended to limit determination of whether a claim has been prematurely closed to those conditions that were accepted at the time of claim closure. Because the legislature's intent is clear from the inquiry into text and context, further inquiry is unnecessary. *PGE*, 317 Or at 610-12.

In this case, claimant's cervical condition was not an accepted condition when the 1996 injury claim was closed on April 2, 1997. Therefore, the issue of whether the cervical condition was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed. Instead, the premature closure issue applies only to those conditions that were accepted at the time of claim closure.

At the time of claim closure, only the left shoulder contusion condition was in accepted status. (Exs. 5, 14, 26). In order to establish that his claim was prematurely closed, claimant must carry the burden of proving by a preponderance of the evidence that the left shoulder condition was not medically stationary on April 2, 1997, the date of claim closure. *See Berliner v. Weyerhaeuser Co.*, 54 Or App 624, 628 (1981). We conclude that claimant has not carried his burden of proof.

Only one physician addressed claimant's medically stationary status near the time of claim closure. On March 20, 1997, Dr. Matteri examined claimant and declared him to be medically stationary. (Ex. 12). Although the medical arbiter, Dr. Filarski, found claimant not medically stationary when he examined claimant on July 11, 1997, he based his decision on claimant's cervical condition, not the accepted left shoulder condition. As to the left shoulder condition, Dr. Filarski stated that it was "essentially resolved" and measured no impairment for that condition. (Ex. 24).

After reviewing the medical opinions in the record, we conclude that claimant has not carried his burden to prove that the accepted left shoulder condition was not medically stationary at claim closure. Dr. Matteri's "medically stationary" opinion is entitled to deference because of his status as claimant's treating physician. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983). Furthermore, Dr. Filarski's opinion must be discounted because it was based on consideration of claimant's cervical condition, which was not accepted at the time of claim closure. As we held in *Mack*, the medically stationary status of non-accepted conditions is irrelevant to the premature closure determination. Because claimant has not carried his burden of proving his claim was prematurely closed, we conclude that the Determination Order properly closed the claim on April 2, 1997.[3] We modify the ALJ's order accordingly.

Furthermore, we note that claimant does not contest any other aspect of the April 2, 1997 Determination Order, which was affirmed by the August 11, 1997 Order on Reconsideration. (Exs. 14, 27). That Determination Order awarded temporary disability benefits for the left shoulder condition but declined to award permanent disability benefits for that condition, finding that the record did not establish any permanent impairment. Claimant does not contest that finding. In any event, the record does not support a finding of any permanent impairment of the left shoulder. (Exs. 12, 24).

Attorney Fees

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

ORDER

The ALJ's order dated October 5, 1998 is reversed in part and affirmed in part. That portion of the order that found claimant's claim prematurely closed and rescinded the April 2, 1997 Determination Order and the August 11, 1997 Order on Reconsideration is reversed. The Determination Order and the Order on Reconsideration are reinstated and affirmed. The remainder of the ALJ's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded a fee of $1,500, payable by the insurer.

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[3] In reaching this conclusion, we remind the parties that the insurer must reopen claimant's claim for processing of the "post-closure" accepted cervical condition. ORS 656.262(7)(c); *see generally Douglas G. Abbott*, 50 Van Natta 1156 (1998); *Art L. Wetzel*, 50 Van Natta 1127 (1998).

In the Matter of the Compensation of
SAMMIE A. PAKROS, Claimant
WCB Case No. 98-01672
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl, Bock and Haynes.

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the factual background of the claim. On January 17, 1997, claimant, a dental hygienist, filed an occupational disease claim for right-side back, arm, wrist, elbow, hand, neck and back pain. (Ex. 3). Dr. James, on referral from Dr. Groskopp, diagnosed carpal tunnel syndrome. SAIF accepted right carpal tunnel syndrome on April 17, 1997. (Ex. 5). Dr. James performed a right carpal tunnel release on June 5, 1997. (Ex. 7). SAIF modified its acceptance on August 29, 1997 to include right wrist overuse syndrome. (Ex. 13).

In October 1997, Dr. James requested that Dr. Grant perform nerve conduction studies and evaluate myofascial complaints in claimant's right shoulder. (Ex. 16-1). Dr. Grant confirmed that claimant had a myofascial right neck, shoulder, periscapular and upper extremity pain syndrome, which was caused in major part by claimant's work as a dental hygienist. (Ex. 16A). On November 14, 1997, SAIF was requested to accept those conditions pursuant to ORS 656.262(6)(d). (Ex. 19).

SAIF then obtained a report from examining physicians, Drs. Schilperoort and Weller, who concluded that "musculoskeletal deconditioning" was the major contributing cause of the development of claimant's right upper extremity, neck and shoulder condition. (Ex. 20-11). SAIF then denied the compensability of right shoulder overuse syndrome, right upper extremity strain, and chronic cervical strain on the ground that the compensable injury was not the major contributing cause of those conditions. (Ex. 23). Claimant requested a hearing.

The ALJ analyzed claimant's claim as one for an occupational disease. The ALJ first held that the cervical strain aspect of the denial was "null and void" because claimant's claim did not include a cervical strain.[1] The ALJ, however, upheld the remainder of SAIF's denial, finding that the medical evidence did not establish that claimant's work activity was the major contributing cause of claimant's myofascial right shoulder syndrome and right shoulder/upper extremity strain condition. In reaching this conclusion, the ALJ found that a preponderance of medical evidence established a preexisting condition composed of hypothyroidism and deconditioning related to obesity and tobacco use which must be considered in the development of claimant's myofascial condition.

On review, claimant contends that deconditioning related to obesity and tobacco use does not qualify as a "preexisting condition" under ORS 656.005(24)[2] and should not be considered a "cause" for the purposes of determining the major contributing cause of her condition. *See* ORS 656.802(2)(e).[3] Moreover, claimant asserts that the Schilperoort/Weller opinion is unpersuasive and that the remainder of the medical evidence proves that her work activity is the major contributing cause of her occupational disease.

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[1] The parties do not contest this portion of the ALJ's order.

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

[3] ORS 656.802(2)(e) provides that "preexisting conditions shall be deemed causes in determining major contributing cause under this section."

We need not address claimant's argument regarding the alleged "preexisting condition." That is, even if personal musculoskeletal deconditioning was a preexisting condition and could be considered a cause of claimant's occupational disease, we would still conclude that her work activity is the major contributing cause of her right upper extremity/shoulder conditions. We reach this conclusion for the following reasons.

In order to establish a compensable occupational disease claim for her right shoulder/upper extremity condition, claimant must prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). Because multiple factors could potentially contribute to claimant's condition, the cause of his occupational disease is a complex medical question which requires expert medical opinion to resolve. *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985). In resolving complex medical causation issues, such as those presented here, medical opinions which are well-reasoned and based on accurate and complete histories are relied on. *See Somers v. SAIF*, 77 Or App 259 (1986). When medical opinions differ, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, several physicians have presented medical opinions regarding the cause of claimant's condition. Dr. Grant, claimant's current attending physician, opined that claimant's myofascial condition was caused in major part by her work as a dental hygienist. (Ex. 16A). While Dr. Grant's opinion is conclusory, it does find support from other medical providers in this record.

In March 1997, a panel of examining physicians, Drs. Farris and Staver, evaluated claimant's right upper extremity complaints. (Ex. 4A). Although the ALJ did not consider this report to be relevant based on his belief that the report only addressed claimant's carpal tunnel condition, the panel diagnosed a right upper extremity overuse syndrome. The doctors opined that, while claimant had a minor element of carpal tunnel syndrome, her condition was more global and could not be explained by even severe carpal tunnel. Drs. Farris and Staver opined that claimant's work activities were the major contributing cause of the overuse condition. (Ex. 4A-6). Dr. Farris submitted a follow-up report in which she attributed claimant's symptoms to her work activities. (Ex. 12-3). Both reports contained a thorough analysis of claimant's musculoskeletal condition and considered the various factors that could be contributing to claimant's condition. We find the Farris/Staver reports to be persuasive evidence supporting compensability.[4]

A physical therapist, Ms. O'Hair, also related the symptoms of claimant's myofascial condition to her employment, noting that claimant's work environment required prolonged periods of turning and elevating her arm above shoulder level. (Ex. 23A-1). In addition, Dr. Sultany, who examined claimant at SAIF's request, noted that, while claimant's right scapulothoracic discomfort could be multifactorial, it was likely related to her work as a dental hygienist. (Ex. 25-5). Moreover, Dr. Sultany indicated he agreed with Dr. Grant's report in which he stated that claimant's work was the major contributing cause of her myofascial condition. (Ex. 25-4).

We recognize that Drs. Schilperoort and Weller attributed claimant's myofascial condition to "personal musculoskeletal deconditioning." (Ex. 20-11). Even if we considered this to be a valid potential cause of claimant's condition, we would not find the Schilperoort/Weller report sufficient to defeat compensability. Based on our review of the Schilperoort/Weller report, we are not persuaded that they gave sufficient consideration to the nature of claimant's work activities in reaching their conclusion. Moreover, we find this opinion outweighed by the preponderance of the medical evidence linking claimant's conditions to her employment.

Accordingly, we find that claimant sustained her burden of proving a compensable occupational disease claim for her right shoulder/upper extremity conditions. Therefore, we reverse.

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[4] We note Dr. Farris' observation that claimant is a deconditioned individual and moderately overweight. Dr. Farris explained the effect of claimant's tobacco consumption on her overall physical condition. She explained that claimant's stamina was decreased and that her deconditioning was increased by her one-and-a half-pack-per-day cigarette habit. (Ex. 12-3). Dr. Farris opined that cigarettes not only decrease circulation to the nerves and muscles but also decrease oxygenation of the blood which is circulated to those areas. According to Dr. Farris, claimant's general deconditioning was also worsened by her increasing age and weight. While Dr. Farris comments regarding the physiological effect of tobacco use are helpful in understanding claimant's physical condition, and we cannot deny that claimant's tobacco use negatively affects her health, the fact remains that Dr. Farris (as well as Dr. Staver) identified work activity as the major factor in claimant's right shoulder/upper extremity conditions. (Exs. 4A-6, 12-3). Therefore, we conclude that, despite claimant's tobacco use, her occupational disease 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 regarding the compensability of claimant's right shoulder/upper extremity conditions is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 29, 1998 is reversed in part and affirmed in part. That portion that upheld SAIF's denial is reversed. SAIF's denial of claimant's right shoulder/upper extremity conditions is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by SAIF. The remainder of the order is affirmed.

Board Member Haynes dissenting.

The majority finds that claimant sustained her burden of proving a compensable occupational disease claim. I agree, however, with the ALJ that claimant has a preexisting condition consisting of hypothyroidism and deconditioning related to obesity and tobacco use. Further, I would find that this preexisting condition was the major contributing cause of claimant's right shoulder and upper extremity condition. Therefore, I must respectfully dissent.

ORS 656.802(2)(e) provides that preexisting conditions shall be deemed causes for determining the major contributing cause of an occupational disease. "Preexisting conditions" are given an expansive definition in ORS 656.005(24), which defines them 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 * * * ."

In this case, claimant has been overweight, a smoker and suffered from hypothyroidism for many years. As the ALJ noted, Dr. Farris opined, without contradiction, that hypothyroidism predisposes a person to muscle and nerve complaints. Moreover, claimant's deconditioning, an important factor in claimant's physical complaints, is increased by her weight and smoking. The ALJ correctly determined that a preponderance of evidence established a preexisting condition consisting of hypothyroidism and deconditioning related to obesity and tobacco use that must be considered a cause of claimant's conditions.

The majority avoids the important issue of determining whether claimant has a preexisting condition by in effect saying that it does not matter because work activities are the major contributing cause of claimant's condition. I disagree, however, with its evaluation of the medical evidence. Dr. Grant diagnosed a myofascial right neck, shoulder, periscapular and upper extremity pain syndrome and opined that claimant's work was the major contributing cause of these conditions. (Ex. 16A). Even the majority concedes that this opinion is conclusory. In addition, Dr. Grant gives no consideration to the impact of the preexisting conditions mentioned above. Clearly, Dr. Grant's opinion is of little significance in deciding the causation issue.

Both Dr. Sultany and Ms. O'Hair merely related claimant's work activities to her symptoms. (Exs. 23A-1, 23). Neither weighed the affect of claimant's preexisting conditions. Neither opined that work was the major contributing cause of claimant's myofascial condition. Although Dr. Farris opined that work activities were the major contributing cause of claimant's "symptoms," this falls well short of proving that work was the major contributing cause of the myofascial condition itself. Moreover, Dr. Farris explained that many other factors were involved in the etiology of this conditon, as she demonstrated by her extensive and persuasive discussion of the adverse effect of claimant's cigarette habit on her myofascial complaints. (Ex. 12-3).

In short, the medical evidence supporting compensability is weak and does not overcome the well-reasoned opinions of Drs. Weller and Schilperoort, who opined that the musculoskeletal deconditioning was the major contributing cause of claimant's physical complaints. (Ex. 20). Because the majority concludes otherwise, I must dissent.

In the Matter of the Compensation of
GREG AKERS, Claimant
WCB Case No. C9-00232
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
James Dodge, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On January 28, 1999, 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 1, the CDA originally provided a total consideration of $19,000, with $3,775 of this amount going to claimant's attorney as a fee, and the remaining $15,225 being paid to claimant. By handwritten interlineation, claimant, claimant's attorney and the insurer's counsel have modified the total consideration to $19,900, with claimant's attorney receiving $4,975[1] and $14,925 to claimant. One provision (page 3, number 13), however, has not been revised and still provides for an attorney fee of $3,775.

Because the "extraordinary fee" provision on page 3, number 19 is consistent with the revisions to the first page of the CDA, it appears that the parties inadvertently neglected to revise paragraph 13 on page 3 which still refers to a fee of $3,775. Accordingly, in interpreting the agreement, we rely on the handwritten revisions on page 1 and page 3, number 19 over the provision in paragraph 13 on page 3.

Under such circumstances, as interpreted herein, the CDA is in accordance with the terms and conditions prescribed by the Board. Accordingly, the CDA, including the extraordinary attorney fee, is approved. ORS 656.236(1); OAR 438-015-0052(1).

In the event that our interpretation of the CDA conflicts with the parties' intentions, the parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order.

IT IS SO ORDERED.

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[1] The agreement has also been revised on page 3, number 19 (with the agreement of all parties), to include "extraordinary circumstances" warranting an attorney fee in excess of the Board's standard attorney fees. OAR 438-009-0052(1).

In the Matter of the Compensation of
WILLIAM B. BARRETT, Claimant
WCB Case No. 98-04366
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) declined to award an attorney fee pursuant to ORS 656.386(1); and (2) declined to assess a penalty for an allegedly unreasonable delay in accepting or denying the claim. On review, the issues are attorney fees and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize the findings as follows.

Claimant compensably injured his back on July 28, 1997. He filed a claim for a back strain. On July 29, 1997, claimant had back pain and mild symptoms of spasm. On August 4, 1997, Dr. Geddes' impression was sciatica resolving and thoracolumbar strain improved. On August 18, Dr. Barlow noted worsening after crawling and twisting at work and diagnosed acute lumbosacral and cervical strains.

On September 5, 1997, the SAIF Corporation accepted a disabling thoracolumbar strain. An October 10, 1997 chart note lists acute lumbar strain exacerbation.

Claimant underwent an MRI on November 13, 1997. The MRI showed prominence of disc material and broad based bulging of the L4-5 disc and a small disc herniation at L3-4.

On March 25, 1998, SAIF issued a Notice of Closure and an updated Notice of Acceptance at closure identifying the accepted condition as thoracolumbar strain.

On April 22, 1998, claimant's attorney wrote to SAIF, stating:

> "Pursuant to ORS 656.262(7)(a), I request that SAIF amend the Notice of Acceptance to formally accept in writing the following additional conditions caused by the on-the-job injury of 7-25-97: lumbosacral strain, L3-4 central and right disc herniation and L4-5 central and left disc bulges, and bilateral lumbar radiculopathy involving left L3, L4, L5 and Right L2 L3 and L4."

SAIF wrote Dr. Lawlor (the physician who had requested the MRI) on May 1, 1998 telling her that claimant had requested the MRI findings be included in the accepted claim and requesting her opinion regarding causation of the conditions.

On June 2, 1998, claimant requested a hearing. On June 12, 1998, SAIF amended its acceptance to include "lumbosacral strain, L4-5 disc bulge, L3-4 right disc herniation, bilateral lumber [sic] radiculopathy."

CONCLUSIONS OF LAW AND OPINION

SAIF amended the Notice of Acceptance within 90 days of claimant's attorney's request, but more than 30 days after the request. Claimant argued at hearing that ORS 656.262(6)(d) applied to his claim and that the conditions identified in the June 2, 1998 amended acceptance notice were conditions improperly omitted from the initial acceptance. Claimant sought an attorney fee pursuant to ORS 656.386(1)(b)(B)[1] for obtaining a rescission of a "de facto" denial. Claimant also sought penalties under

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[1] ORS 656.386(1)(b)(B) provides that a denied claim includes: "A claim for compensation for a conditions 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[.]"

ORS 656.262(11)(a) for an allegedly unreasonable delay in acceptance or denial of the claim. SAIF argued that the conditions were "new medical conditions" pursuant to ORS 656.262(7)(a) and that the conditions were timely accepted under that statute.

The ALJ declined to award a penalty or attorney fee concluding that the disputed conditions were more appropriately classified as new medical conditions rather than conditions omitted from the acceptance because they had not been diagnosed at the time of acceptance.

After the date of the ALJ's order, we issued our decision in *Mark A. Baker*, 50 Van Natta 2333 (1998). In *Baker*, we found, based on the text and context of ORS 656.262(6)(d) and (7)(a), 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. We further found that a condition that was incorrectly omitted from a Notice of Acceptance under ORS 656.262(6)(d) is one that was in existence at the time of the notice, but is not mentioned in the notice or is left out.[2]

With the exception of radiculopathy, none of the claimed disc conditions were identified or diagnosed until after the issuance of the Notice of Acceptance and the record contains no medical evidence addressing when the disputed disc conditions came into being. Pursuant to our holding in *Baker*, the lumbar radiculopathy was a condition omitted from the Notice of Acceptance because it was in existence at the time of the notice but was left out. With regard to the remaining disc conditions, we agree with the ALJ that the conditions are most appropriately processed as "new medical conditions" under ORS 656.262(7)(a) rather than conditions incorrectly omitted from the notice pursuant to ORS 656.262(6)(d). Under such circumstances, we award an attorney fee under ORS 656.386(1)(b)(B) only for the lumbar radiculopathy condition.

Based on the record, claimant's attorney wrote SAIF requesting acceptance of the radiculopathy condition and filed a hearing request. Thus, we find that claimant's attorney was instrumental in obtaining a rescission of the "de facto" denial of the lumbar radiculopathy condition without a hearing. *See* ORS 656.386(1).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services in obtaining a pre-hearing rescission of the lumbar radiculopathy condition is $150, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee on review regarding his counsel's services regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

Inasmuch as the record contains no evidence establishing amounts then due upon which to base a penalty under ORS 656.262(11)(a), no penalty may be awarded.

ORDER

The ALJ's order dated October 29, 1998 is reversed in part and affirmed in part. The ALJ's order is reversed to the extent it declined to award an attorney fee pursuant to ORS 656.386(1)(b)(B) for claimant's counsel's services regarding the lumbar radiculopathy condition. Claimant's attorney is awarded $150 for services regarding the lumbar radiculopathy condition, payable by SAIF. The remainder of the ALJ's order is affirmed.

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[2] Claimant also argues that "lumbosacral strain" should have been accepted within 30 days. Claimant argues that SAIF's acceptance of thoracolumbar strain did not include claimant's "sacral condition." Our review persuades us that claimant has only one back strain condition. Based on the medical record, we find that the physicians used the terms thoracolumbar strain and lumbosacral strain interchangeably to refer to the same strain condition. Thus, we find that SAIF's initial acceptance of thoracolumbar strain included the lumbosacral strain condition. *See* ORS 656.262(7)(a) (carrier is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions).

In the Matter of the Compensation of
MARVIN H. BENZ, Claimant
WCB Case No. 98-04562
ORDER ON REVIEW
Burt, Swanson, Lathen, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

Compensability Based on Exposure With Employer

We adopt and affirm the ALJ's conclusion and rationale on this issue with the following comment. Claimant argued at hearing that Dr. Frink's opinion established that claimant's noise-exposure with the employer was the major cause of his hearing loss. The ALJ relied on the contrary opinion of Dr. Ediger. On review, claimant argues that the ALJ erred in concluding that Dr. Frink's rationale was similar to the analysis rejected by the Board in *Henry S. Downs*, 48 Van Natta 2094 (1996). Independent of his reliance on the Downs decision, the ALJ set forth a number of other persuasive reasons why he relied on the opinion of Dr. Ediger over Dr. Frink. We affirm the ALJ's ultimate decision based on this independent rationale.

Compensability Under LIER

On review, claimant reiterates his argument at hearing that, under the "rule of proof" component of the Last Injurious Exposure Rule (LIER), he has established the compensability of his hearing loss. *See Gosda v. J. B. Hunt Transportation,* 155 Or App 120 (1998). We affirm the ALJ's ultimate decision on this issue based on the following alternative rationale.

Claimant relies on Dr. Frink's opinion that claimant's work exposure with all employers is the major contributing cause of his hearing loss. Claimant argues that Dr. Frink's opinion is persuasive because he is the only expert who evaluated the contribution from all prior work activity. While Dr. Frink's opinion is unrebutted, claimant's testimony and the history he gave Audiologist Rheinfelder and Dr. Ediger do not support Dr. Frink's assumed history of exposure to harmful noise levels. Thus, we are not persuaded that Dr. Frink's opinion is based on an accurate work history. For this reason, we affirm the ALJ's ultimate conclusion that Dr. Frink's opinion does not establish compensability of claimant's hearing loss under the LIER "rule of proof."

ORDER

The ALJ's order dated October 5, 1998 is affirmed.

In the Matter of the Compensation of
CALVIN A. KAEO, Claimant
WCB Case No. 98-03392
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a $4,500 attorney fee. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation on the attorney fee issue.

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). The parties offered argument about claimant's attorney fee during closing arguments (included in the record as Exhibit 26) and claimant requested a fee of $7,500, without submitting his counsel's statement of services. The ALJ awarded claimant's attorney an assessed fee of $4,500 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)[1] 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. SAIF does not argue that the $4,500 fee awarded by the ALJ is excessive, nor does it make any specific arguments regarding the factors provided by OAR 438-015-0010(4).

Claimant argues that the ALJ's fee award should be affirmed, "given the time involved in this case, the deposition, the necessity of solicitation of medical opinions, the benefits of surgery and approximately six months of time loss, at a high rate, for [c]laimant, the skill of both counsel, and the risk that [c]laimant's counsel would go uncompensated."

The ALJ in this case simply ordered SAIF to pay claimant's attorney "an assessed fee of $4,500 for his services in setting aside its denial, to be paid in addition to claimant's compensation." 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 $4,500 as a reasonable attorney fee. *See Daryl L. Underwood*, 50 Van Natta 2330 (1998).

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. *Underwood*, 50 Van Natta at 2332. 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.

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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."

As indicated above, claimant's attorney did not submit a statement of services showing the time devoted to the case. The record consists of approximately 47 exhibits, including two letters from claimant's treating physicians, responding to claimant's counsel's inquiries in a manner favorable to claimant's position. The record also includes a "post-hearing" physician's deposition 42 pages long.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of above average medical and legal complexity, considering the combined condition and the "*SAIF v. Nehl*" issue. The value of the interest and benefit secured were significant, considering claimant's surgery and time loss. Both attorneys are skilled litigators with substantial experience in workers' compensation law. No frivolous issues or defenses were presented. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated, considering the complexity of the case.

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 $4,500, payable by SAIF. 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 counsel might have gone uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review defending against SAIF's appeal of the ALJ's compensability decision. 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, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee on review for his counsel's services regarding the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 2, 1998 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, payable by the SAIF Corporation.

February 18, 1999 Cite as 51 Van Natta 290 (1999)

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 97-0181M
OWN MOTION ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our February 4, 1999 Own Motion Order Reviewing Carrier Closure, in which we affirmed the insurer's August 26, 1998 Notice of Closure in its entirety.

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
WILLIAM J. KEPHART, Claimant
WCB Case No. 98-04978
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Thye's order that assessed a $3,500 fee for claimant's counsel's services at hearing. SAIF also requested remand. Claimant cross-requests review, asserting that the attorney fee should be increased. 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.

Claimant requested a hearing challenging SAIF's denials of his left knee condition. The ALJ found claimant's current left knee condition compensable and an aggravation of a prior compensable left knee injury. The ALJ also assessed an attorney fee of $3,500 "after considering the factors set forth in OAR 438-015-0010 and applying them to this case."

On review, SAIF asserts that the ALJ failed to provide a sufficient explanation for the assessed fee, and seeks remand to the ALJ. Contrary to SAIF's contention, an ALJ is not required to make specific findings regarding the factors set forth in OAR 438-015-0010(4) where, as here, there is no specific attorney fee requested[1] and the parties did not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee. *Daryl L. Underwood*, 50 Van Natta 2330 (1998). The ALJ satisfies his or her obligation to make findings in a case by including in the order a brief description or citation to the rule-based factor or factors the ALJ relied on in determining the attorney fee awarded. *Id.* (*citing McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)). Furthermore, because we are authorized to modify or supplement an ALJ's findings and conclusions under ORS 656.295(6), it is not necessary for us to remand a case to an ALJ for the supplementation of findings regarding an attorney fee award. *Underwood*, 50 Van Natta at 2332.

Here, the ALJ specifically indicated that the $3,500 assessed attorney fee was based upon the factors set forth in OAR 438-015-0010. The ALJ also indicated that, in reaching his conclusion, he considered the time devoted to the case, the complexity of the issue, the risk that counsel may go uncompensated, the value of the interest involved and the benefit to claimant. Therefore, the ALJ applied the proper standard in determining a reasonable attorney fee. Under such circumstances, neither modification of the ALJ's order nor remand to the Hearings Division is necessary.

On de novo review, we also find no reason to modify the amount of the ALJ's attorney fee award.[2] The issues at hearing were the compensability of claimant's current combined left knee condition and whether he sustained an aggravation of his accepted left medial meniscus tear. Claimant was the only witness to testify and the hearing lasted only one hour. The transcript consists of 10 pages. The record contains 57 exhibits, approximately 14 of which were generated by claimant. The factual and medical issues presented by this compensability/aggravation case are similar to those generally submitted to the Hearings Division for resolution, even though a combined condition was in issue. The value of the claim and the benefits secured are significant, and the attorneys were skilled and presented well-reasoned arguments.

Although there was also risk that claimant's counsel's efforts might have gone uncompensated, that fact does not require the strict mathematical application of a contingency factor or "multiplier." *See,*

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[1] Claimant's counsel submitted a statement of services indicating what services were performed on specific dates, but did not indicate the time spent on those services nor did he request a specific attorney fee at hearing.

[2] On review, claimant requests a fee of $5,440 for his counsel's services at hearing, based upon 17 hours at $160 per hour and a multiplier of 2. We may consider this specific fee request on review pursuant to the provisions of OAR 438-015-0029(1).

e.g., Lois J. Schoch, 49 Van Natta 788, 790, n 1 (1997); *Lois J. Schoch*, 49 Van Natta 170, 173, n.1 (1997). Rather, the risk that claimant's counsel may go uncompensated is to be considered in conjunction with the other relevant factors of OAR 438-015-0010(4) in evaluating the ALJ's attorney fee award. *See, e.g., John M. Morley*, 50 Van Natta 1598 (1998). In this case, after considering the rule-based factors (including claimant's counsel's representation as to the time devoted to the case), we find the ALJ's $3,500 attorney fee award adequate and reasonable.[3]

ORDER

The ALJ's order dated November 17, 1998 is affirmed.

[3] Because SAIF challenged only the attorney fee award on review and 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 review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

February 16, 1999 Cite as 51 Van Natta 292 (1999)

In the Matter of the Compensation of
RONALD K. KNOX, Claimant
WCB Case No. 98-04572
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that assessed a $2,500 attorney fee. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of claimant's injury or occupational disease claim for an L4-5 disc condition.[1] On review, the issues are compensability and attorney fees.

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

Claimant's attorney is entitled to a reasonable assessed fee for services provided at hearing in prevailing over SAIF's denial of claimant's L4-5 nerve root irritation. ORS 656.386(1). Neither party submitted any argument to the ALJ as to how the factors in OAR 438-015-0010(4)[2] 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 $2,500 for services at hearing related to partially prevailing over SAIF's denial, considering the factors in OAR 438-015-0010(4).

[1] The ALJ set aside SAIF's denial to the extent that it denied L4-5 nerve root irritation. That portion of the ALJ's order has not been contested.

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

"(a) The time devoted to the case;

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

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

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

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

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

On review, SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award. SAIF does not argue that the $2,500 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 the ALJ was *required* by the rule to make findings of fact under *each* of the eight factors in OAR 438-015-0010(4); draw conclusions from those specific findings of fact; and demonstrate how those conclusions should be weighed in determining a reasonable attorney fee. We disagree with SAIF's arguments, as we have previously explained in *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, the ALJ awarded a $2,500 attorney fee, having "considered the eight factors set forth in OAR 438-015-0010, especially the time and effort devoted to this case, the value and nature of the results obtained for the injured worker, and the risk that claimant's attorneys may go uncompensated." As in *Underwood*, the ALJ was 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.

Moreover, 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. The hearing lasted about an hour. Claimant was the only witness who testified. The record consists of 11 exhibits, including a letter from claimant's counsel to Dr. Bert, with the doctor's responses to questions about claimant's condition. Dr. Bert's responses were favorable to claimant's position.

Based on compensability disputes generally litigated before this forum, we find the compensability issue was of average legal complexity and above average medical complexity, considering claimant's multiple diagnoses and his preexisting conditions. The value of the interest and benefit secured were also in the average range.[3] Both attorneys presented their cases in a thorough and skillful manner. No frivolous issues or defenses were presented. Finally, although there was a risk that claimant's counsel's efforts might have gone uncompensated, the risk was not as great as those generally presented to this forum because the evidence concerning causation of the L4-5 nerve root irritation condition is essentially in agreement that the condition is work-related.

After considering the factors set forth in OAR 438-015-0010(4), we agree with the ALJ that a reasonable fee for claimant's attorney's services at hearing regarding the L4-5 nerve root irritation condition is $2,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved. 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 defending the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.* 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 2, 1998 is affirmed.

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[3] In reaching this conclusion, we note the compensable L4-5 nerve root irritation is the condition currently causing claimant's low back problems, but his preexisting low back conditions are not compensable.

In the Matter of the Compensation of
DEANA F. MARSHALL, Claimant
WCB Case No. 92-09708
SECOND ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Supreme Court. *Marshall v. SAIF*, 328 Or 49 (1998). The Supreme Court has affirmed the Court of Appeals opinion, 146 Or App 50 (1997), that had reversed our prior order, *Deana F. Marshall*, 47 Van Natta 1686 (1995), which had upheld the SAIF Corporation's denial of claimant's occupational disease claim for a right shoulder and arm condition. Concluding that sufficient corroborative evidence was present to support claimant's "sole proprietor" claim under ORS 656.128(3), the Supreme Court has remanded this case to the Board for further proceedings.

The Supreme Court has determined that 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*. Applying that rationale, the Court has concluded that claimant's attending physician's medical report provided sufficient corroboration of the *existence* of her tendinitis claim and likewise corroborated her assertion that the tendinitis was *work-related*.

In light of these determinations, we find that claimant has established the compensability of her claim. Consequently, as supplemented and modified by the Supreme Court's opinion and by this order, we adopt and affirm those portions of the Administrative Law Judge's (ALJ's) January 13, 1993 decision that: (1) set aside SAIF's denial of claimant's occupational disease claim for a right shoulder and arm condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial and an allegedly unreasonable discovery violation. We do not adopt the ALJ's findings, reasoning, and conclusions regarding the inapplicability of ORS 656.128(3).

Accordingly, in lieu of our previous orders on remand, we republish our August 31, 1993 order, as supplemented and modified herein, that affirmed the ALJ's order dated January 13, 1993.

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD D. MORRISON, Claimant
WCB Case No. 97-10003
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for cervical and lumbar strain conditions, contusion to ribs and scalp, and post-traumatic stress disorder. On review, the issue is compensability.

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

We reject claimant's contention that his claim for a mental disorder should be analyzed as an "injury." In *Jackie T. Ganer*, 50 Van Natta 2189, *on recon*, 51 Van Natta 116 (1999), we held that a claim for a *consequential* mental condition is properly analyzed under ORS 656.005(7)(a)(A). In reaching our conclusion, we reasoned that, consistent with the Supreme Court's rationale in *Fuls v. SAIF*, 321 Or 151 (1995), when a worker brings an *independent* claim for a mental condition, the applicable statute is ORS 656.802. Here, unlike the condition in *Ganer*, claimant's mental condition is an independent claim, not a consequential claim. Therefore, claimant must satisfy ORS 656.802 and his claim for acute stress disorder is subject to the "major contributing cause" standard under ORS 656.802(1)(a)(B).

Claimant must also 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 they must be conditions other than those generally inherent in every working situation (or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment). Finally, 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.

On this record, we find that claimant has carried his burden of proof in all respects. He has a generally recognized diagnosis of a mental disorder and the existence of his condition is established by medical evidence supported by objective findings; the employment conditions claimed to cause the disorder existed in a real and objective sense; and they were not conditions generally inherent in every working situation. We note that Dr. Lazar, long-time treating physician, and Mr. Maynard, treating psychologist, were in advantageous positions for evaluating claimant's credibility and the nature of his problem. For this reason, and considering their well-reasoned opinions, we agree with the ALJ that those opinions are persuasive. (*See* Exs. 38A, 40, 41, 43-10-11, 44-7-9, 44-11-16).

In addition, based on this persuasive evidence, which we find to be clear and convincing, we conclude that claimant has carried his burden of proving that his employment conditions were the major contributing cause of his acute stress disorder condition.[1] (*See id.*). Consequently, we agree with the ALJ 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 $1,600 payable by the insurer. 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 August 11, 1998 is affirmed. For services on review, claimant is awarded a $1,600 attorney fee, payable by the insurer.

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[1] We are not persuaded that claimant had a preexisting psychological condition or that noncompensable factors contributed to his acute stress disorder condition. (*See* Exs. 43-3, 43-5, 43-7-8, 43-10).

In the Matter of the Compensation of
DORA A. SMITH, Claimant
WCB Case No. C9-00270
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Member Bock and Biehl.

On February 1, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The first page of the proposed CDA provides that the total amount due claimant is $900 and the total due claimant's attorney is $225. This would equal a total consideration of $1,125. The total consideration recited on the third page of the document, however, is "$900" instead of $1,125. Additionally, on page three of the CDA, the attorney fee is given as $225, an amount consistent with the "attorney fee" portion of the first page of the document, *former* OAR 438-015-0052(1)[1] and a total consideration of $900. We rely on the more specific provision in the body of the agreement over the first page of the document. *Carol J. Mullins*, 51 Van Natta 198 (1999). Accordingly, consistent with the third page of the CDA, we interpret the agreement as providing for a total consideration of $900, $675 to claimant and $225 to claimant's attorney.

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 $225, 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.

[1] Under the *former* version of the rule (the rule in effect when the parties executed their agreement), 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. Based on this rule, an attorney fee of $225 would be consistent with a total consideration of $900.

In the Matter of the Compensation of
THOMAS G. DOBSON, Claimant
WCB Case No. 97-09982
ORDER ON RECONSIDERATION
Donald M. Hooton, Claimant Attorney
Lundeen, et al, Defense Attorneys

On January 20, 1999, we abated our December 22, 1998 Order on Review that: (1) determined that claimant's claim should not be reclassified as disabling; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claims processing. Claimant seeks reconsideration and submits an October 8, 1998 report from Dr. Buuck, which he contends was not available at the time of hearing. Claimant requests remand to the Administrative Law Judge (ALJ) for purposes of reopening the record and considering the new exhibit. Alternatively, claimant argues that our conclusion that his claim should not be reclassified as disabling is not supported by the evidence. Having received the insurer's response, we proceed with our reconsideration.

Remand

On reconsideration, claimant submits an October 8, 1998 report from Dr. Buuck and requests remand to the ALJ for purposes of reopening the record and considering the new exhibit. Claimant contends that the report was not available at the time of hearing, concerns disability and is reasonably likely to affect the outcome of the case. He argues that the presence of significant atrophy more than two years after the date of injury indicates that he is reasonably likely to experience permanent disability as a result of the claim. On the other hand, the insurer contends that Dr. Buuck's opinion was "obtainable" before the record closed, even though it was not yet available.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See* ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). 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); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we agree with claimant that Dr. Buuck's October 8, 1998 report was not "available" at the time of the July 9, 1998 hearing. At hearing, the "reclassification" issue involved consideration of whether temporary disability benefits became due and payable and whether there was a reasonable expectation that claimant's injury would result in permanent disability. Dr. Buuck's October 8, 1998 report concerns claimant's disability. We find that consideration of this evidence creates a reasonable likelihood that the outcome of this case would be affected. *See Cain v. Wooley Enterprises*, 301 Or 650, 654 (1986). The more difficult question is whether this evidence was "obtainable" at the time of hearing.

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. In the *Compton* case, the court held that an erroneous factual foundation or change of opinion did not create "unobtainable" evidence. *Id.* at 648. The court determined that the evidence at issue may not have been made available at the hearing, but it certainly was "obtainable." *Id.; see, e.g., Felicitas Deleon*, 46 Van Natta 2209 (1994); *James E. Gore*, 45 Van Natta 1652 (1993) ("evidence is not newly discovered merely because it was generated after the hearing.").

In this case, claimant compensably injured his neck and left knee on July 17, 1996. (Ex. 2). Dr. Croy performed arthroscopic knee surgery on February 21, 1997. (Ex. 18). Claimant signed an "801" form on August 11, 1997. (Ex. 21). On November 25, 1997, the insurer accepted a nondisabling cervical strain/left knee contusion. (Ex. 25). On December 5, 1997, claimant's attorney wrote to the insurer, requesting that it reclassify his claim as disabling and expand its acceptance to include other conditions. (Ex. 26). On the same date, claimant's attorney signed a request for hearing on the issues, including reclassification.

The hearing was held on July 9, 1998 and the record was closed on that date. The reclassification issue at hearing was dependent on whether temporary disability benefits became due and payable and whether there was a reasonable expectation that permanent disability would result from the

July 17, 1996 injury. *See* ORS 656.005(7)(c) (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). The record included reports from Dr. Croy, as well as claimant's testimony. Claimant did not request a continuance to keep the record open for the purpose of receiving any additional reports from Dr. Croy or any other physician.

After the hearing, claimant was examined by Dr. Buuck on October 8, 1998. Although Dr. Buuck's report was not available at the time of hearing, we are not persuaded that the information in his report was unobtainable with the exercise of due diligence at the time of hearing. There is no evidence that claimant could not have obtained a report from Dr. Croy, claimant's treating surgeon, as to whether there was a reasonable expectation that permanent disability would result from the July 17, 1996 injury. Moreover, claimant did not request that the record be left open for the purpose of obtaining such a report from Dr. Croy or another physician. In his brief on reconsideration, claimant asserts that Dr. Buuck did not make any findings that would suggest that there had been a change in claimant's condition since September 8, 1997. Under these circumstances, although Dr. Buuck's report was not available at the time of hearing, we are not persuaded that the substance of his opinion was not obtainable with due diligence at the time of hearing. *See Compton v. Weyerhaeuser Co.*, 301 Or at 648; *Felicitas Deleon*, 46 Van Natta at 2210. For these reasons, we deny claimant's request for remand.

Classification

Claimant argues that our conclusion that his claim should not be reclassified as disabling is not supported by the evidence. After considering the arguments in claimant's motion, we have nothing further to add to our previous order. We adhere to our previous opinion that claimant has failed to meet his burden of proving that he lost time from work as a result of his disability in excess of the three-day waiting period and that he failed to establish that there is a reasonable expectation of permanent disability due to the accepted conditions.

On reconsideration, as supplemented herein, we adhere to and republish our December 22, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANE C. PENN, Claimant
WCB Case No. 98-05985 & 98-05865
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Hoffman Hart & Wagner, 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: (1) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's right elbow/arm; and (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's left elbow/arm. On review, the issue is extent of scheduled disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the last paragraph on page 3, we change the citation after the last sentence to read: "(Ex. 99)." In the first sentence on page 4, we change the date to June 10, 1998.

CONCLUSIONS OF LAW AND OPINION

In October 1996, claimant filed a claim for elbow problems. (Ex. 2). The employer accepted disabling bilateral epicondylitis. (Ex. 32). On June 10, 1998, the claim was closed by Notice of Closure

that awarded only temporary disability. (Ex. 94). An Order on Reconsideration issued on July 10, 1998, awarding claimant 5 percent scheduled disability for loss of use or function of each forearm (wrist). (Ex. 106). The ALJ modified the Order on Reconsideration to award claimant 5 percent scheduled permanent disability for loss of use or function of each elbow/arm.

The employer contends that claimant is not entitled to an award of scheduled disability for a chronic condition of her elbows. The employer also argues that the ALJ erred when he changed the permanent disability rating from a wrist to an arm.

We agree with the ALJ's reasoning and conclusion that claimant is entitled to a 5 percent scheduled chronic condition award for each upper extremity. Nevertheless, for the following reasons, we agree with the employer's alternative argument that the ALJ's order should be modified to change the disability rating from the arms to the forearms (wrists), thereby affirming the Order on Reconsideration.

The ALJ concluded that claimant's injury was deemed to be an injury to the elbow and arm rather than the wrist/forearm. On review, claimant argues that the accepted condition, bilateral epicondylitis, is an inflammation of the epicondyle or the tissues adjoining the epicondyle of the humerus. Claimant contends that, because the humerus is part of the arm and is affected by epicondylitis, it is appropriate to rate the arm as the scheduled disability, rather than merely the wrist or forearm. We disagree.

Dr. Ferguson, claimant's treating physician, agreed that claimant should have permanent restrictions pertaining to repetitive gripping and pinching, as well as repetitive finger movement of the index fingers. (Ex. 99-1). We are not persuaded that claimant's *elbows* were restricted to performing repetitive gripping or pinching. Rather, the medical evidence establishes that her hands were so restricted. Dr. Ferguson reported on April 2, 1998 that the "repetitive gripping and pinching is really causing more problems in her *hands*." (Ex. 86; emphasis added). Moreover, Dr. Ferguson found there was "no evidence of any sustained impairment from the injury to her elbow[.]" (Ex. 88). Dr. Ferguson's reports establish that the restrictions were placed on claimant's hands, not her elbows or arms.

The July 10, 1998 Order on Reconsideration found that, based on reports from Drs. Ferguson and Scheinberg, claimant had "significant restrictions on repetitive pinching, gripping, and ulnar deviation of her *hands* as a result of the epicondylitis." (Ex. 106-2; emphasis added). The Department found that "there were no restrictions placed on use of her *elbows/arms*." (*Id.*; emphasis added). We agree with the employer that the ALJ's order should be modified to change the disability rating from the arms to the wrists. We therefore affirm the Order on Reconsideration award of 5 percent scheduled disability for loss of use or function of each forearm (wrist).

Finally, because claimant successfully defended against the employer's request for hearing seeking reduction or disallowance of her scheduled permanent disability award, claimant is entitled to an employer-paid attorney fee under ORS 656.382(2) for services at hearing 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 at hearing for successfully defending against the employer's request for reduction of her scheduled permanent disability award is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the 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 October 22, 1998 is modified. The Order on Reconsideration award of 5 percent scheduled disability for loss of use or function of each forearm (wrist) is reinstated and affirmed. For services on review regarding the self-insured employer's attempt to reduce claimant's scheduled permanent disability award, claimant's attorney is awarded a $750 attorney fee, payable by the employer.

In the Matter of the Compensation of
LINDA L. CORNELL, Claimant
WCB Case No. 98-03729
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a right carpal tunnel syndrome (CTS) condition; and (2) declined to award an assessed attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

Dr. Mayhill, examining orthopedist, opined that a wrist ratio when elevated (above 0.70) indicated there was less "room" in the carpal canal. (Ex. 19-2). Dr. Mayhill measured claimant's wrist ratio as 0.69 on the *left* and 0.72 on the right, finding the right wrist ratio to be slightly elevated. (Exs. 14-5, 19-1-2).

Claimant reported that she had: (1) borderline diabetes that was controlled by diet; and (2) thyroid or other endocrine/glandular problems from 1995 to present, which were treated at Kaiser Permanente. (Exs. 11-2, 14-2). On the other hand, Dr. Brooks, treating neurologist, stated that a March 18, 1998 blood test showed that claimant's glucose and thyroid studies were within normal ranges. (Ex. 24-1).

Dr. Weinstein, treating physician, provided a check-the-box opinion agreeing with claimant's attorney's statement that claimant's work activities were the major contributing cause of her CTS condition, need for treatment and/or disability. (Ex. 23A-2). Because this opinion is so conclusory, we decline to give it any probative weight. *See Marta I. Gomez*, 46 Van Natta 1654 (1994) (the persuasiveness of a "check the box" opinion depends upon the persuasiveness of the foundation upon which the opinion is based). Dr. Welch, treating surgeon, only indicated that he concurred with the opinions of Dr. Brooks, claimant's treating neurologist. (Ex. 26). Because Dr. Welch's opinion provides no independent analysis, it is only as persuasive as Dr. Brooks' opinion itself.

Only Dr. Brooks provides an explained causation opinion that supports claimant's right CTS condition. (Exs. 24, 25, 27). For the reasons addressed by the ALJ, we find Dr. Brooks' opinion unpersuasive. Therefore, we agree with the ALJ that claimant failed to meet her burden of proof.

ORDER

The ALJ's order dated October 14, 1998 is affirmed.

In the Matter of the Compensation of
SCOT W. LEE, Claimant
Own Motion No. 98-0516M
Second Interim Own Motion Order Consenting to Designation of Paying Agent (ORS 656.307)
Liberty Northwest Ins. Corp., Insurance Carrier

On December 29, 1998, we declined to consent to the Department designating a paying agent under ORS 656.307 because the record contained no evidence that surgery or hospitalization was requested for claimant's current left shoulder condition. Since issuance of our order, Liberty Northwest Corporation (Liberty Northwest) has submitted claimant's request for temporary disability compensation for his 1990 accepted lumbar strain and left shoulder rotator cuff tendinitis claim. Claimant's aggravation rights on that claim expired May 22, 1996. Liberty Northwest has recommended that we deny reopening of claimant's 1990 injury claim, contending that it is not responsible for claimant's current condition for which surgery has been recommended.

In addition, the Benefits Section of the Workers' Compensation Division (WCD) has further provided notification that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer (including Liberty Northwest under claimant's 1990 claim) has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Under such circumstances, WCD seeks our response to its request for consent to an order designating a paying agent under ORS 656.307.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

Here, on December 15, 1998, Dr. Switlyk, claimant's attending physician, recommended that claimant undergo an arthroscopy of his left shoulder and possibly a bursectomy and exploration of his rotator cuff. Because the record establishes that claimant's current condition requires surgery, and, thus, has met the requirements of ORS 656.278 for authorization of temporary disability compensation, we conclude that claimant would be entitled to own motion relief if the own motion carrier (Liberty Northwest) should be ultimately found responsible for the payment of compensation. *See Gary W. Yeager, Sr.*, 48 Van Natta 2293 (1996); *Steven M. Rossiter*, 47 Van Natta 34 (1995); *Robyn Byrne*, 47 Van Natta 213 (1995).

Inasmuch as claimant would be entitled to own motion relief if the own motion insurer (Liberty Northwest) is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1990 own motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of a paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately not found responsible, or if a non-own motion carrier is ultimately found to be the responsible carrier. Furthermore, if the own motion carrier (Liberty Northwest) is ultimately determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.[1]

IT IS SO ORDERED.

[1] This order, which is based on a record supporting a conclusion that claimant's undisputed compensable condition requires surgery, replaces our December 29, 1998 order.

In the Matter of the Compensation of
RONALD W. MORFITT, Claimant
WCB Case No. 98-05566
ORDER ON REVIEW
Welch, Bruun & Green, 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) Peterson's order that awarded a $4,000 attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees.

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

The ALJ set aside SAIF's denial of claimant's claim for a low back injury and awarded an assessed attorney fee of $4,000 pursuant to ORS 656.386(1). Citing *Schoch v. Leupold & Stevens*, 325 Or 112, *on remand* 49 Van Natta 788 (1997), SAIF asserts that the ALJ did not state a sufficient rationale to support the $4,000 attorney fee award. SAIF moves to remand the case to the ALJ to make reviewable findings supporting the award of attorney fees in light of the factors in OAR 438-015-0010(4).[1]

The record contains no specific attorney fee request, such as a statement of services, nor does it appear that the parties submitted to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Under such circumstances, the ALJ was not obligated to make specific findings regarding the rule-based factors in order to have a reviewable order. *Russell L. Martin*, 50 Van Natta 313 (1998) (the absence of a fee request or argument based on the rule-based factors distinguished the case from *Schoch*, 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). *See also McCarthy v. Oregon Freeze Dry Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998) (Court of Appeals would satisfy its obligation to make findings under attorney fee statute by including a brief description or citation to the factor or factors relied on in denying an award of attorney fees; standing alone, absence of explanatory findings to support an award or denial of attorney fees is not a ground for reversal).

Accordingly, it would have been sufficient for the ALJ to state that he had considered the rule-based factors. *See Daryl L. Underwood*, 50 Van Natta 2330 (1998). 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 $4,000 as a reasonable attorney fee.

Nevertheless, we do not find the record to be improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). In other words, because we may modify or supplement the ALJ's order on review, it is not necessary to remand this case to the ALJ for the supplementation of findings regarding claimant's attorney fee award. *Underwood*, 50 Van Natta at 2332. Consequently, we deny SAIF's motion for remand and proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee for services at hearing.

With regard to the time factor, as noted above, claimant's attorney did not submit a statement of services. The hearing transcript is 32 pages long and 3 witnesses testified. The record consisted of approximately 15 exhibits, including one medical report obtained by claimant's attorney.

The compensability issue was medically complex given claimant's preexisting condition. The value of the interest involved and the benefit secured for claimant were significant in that claimant will now obtain medical benefits for his low back condition. Because the medical evidence concerning the compensability of the low back condition was divided, there was a risk claimant's attorney might go uncompensated. Finally, both attorneys were experienced and skillful.

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[1] OAR 438-015-0010(4) provides that the following factors shall be considered in determining a reasonable attorney fee: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

Based on these factors, we agree with the ALJ that $4,000 is a reasonable attorney fee for claimant's counsel's services at hearing regarding the compensability issue. Thus, we affirm.[2]

ORDER

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

[2] Claimant's attorney is not entitled to an assessed fee on review for defending the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

In the Matter of the Compensation of
DIANE J. LUNENBURG, Claimant
WCB Case No. 98-02077
ORDER ON REVIEW
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a neck and back condition; and (2) declined to award a penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

Citing the Oregon Constitution, claimant objects to the delay in the briefing schedule.[1] Any "delay," however, was prompted by the need to respond to claimant's "Response to Transcript Mailing." This resulted in two omitted pages of transcript being provided to the parties. In addition, it was necessary to clarify Board procedures and revise the briefing schedule, as a result of which claimant was given additional time to submit her appellant's brief. Under these circumstances, we are not persuaded that any "delay" in Board review was unreasonable.

Claimant also expresses concern on review, as she did at hearing, regarding compliance with SAIF's subpoenas. As the ALJ noted, however, claimant was provided with an extensive and unfettered opportunity to serve subpoenas, develop the record and obtain counsel. We are not persuaded that there were any constitutional, statutory or administrative violations.

Claimant also objects to the presence of the employer representative (Mr. Yamaka) at hearing. Claimant alleges that Mr. Yamaka's wife is the coordinator for the administrative rules publication through the Secretary of State's office. It is unclear from claimant's comments how this prejudiced or violated any of her constitutional or statutory rights. The ALJ's decision to uphold the denial was based on the *medical* record, not administrative rules or information from Mr. Yamaka.

Claimant asserts that part of the hearing testimony has been excluded from the transcript and that the remaining history has been "reconstructed." We find no basis for claimant's allegations. The record, both documentary and testimonial, is both accurate and complete.

Finally, claimant refers to "new" administrative rules effective September 13, 1998. She asserts that these rules are a direct violation of the Oregon Constitution. The rules to which claimant refers have no relevance to the issues addressed in this case. Thus, claimant's "constitutional violation" concerns are unfounded.

ORDER

The ALJ's order dated September 24, 1998 is affirmed.

[1] Claimant has also requested expedited review. Inasmuch as review has been conducted and this order has issued in an expedited manner, it is unnecessary to further address claimant's request.

In the Matter of the Compensation of
ANSELMO ENRIQUEZ, JR., Claimant
WCB Case No. 98-02358
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) found that claimant's low back injury claim was not prematurely closed; and (2) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's low back condition. On review, the issues are premature closure and extent of unscheduled permanent disability.[1]

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

The ALJ found that claimant was medically stationary when the September 30, 1997 Determination Order closed his low back injury claim. The ALJ also reasoned that the rules governing administrative claim closure do not apply to this closure, because claimant was medically stationary and the rules do not apply unless the worker is *not* medically stationary. Accordingly, the ALJ affirmed the February 20, 1998 Order on Reconsideration, which had modified claimant's medically stationary date but otherwise affirmed a September 30, 1997 Determination Order.

Claimant argues that the September 30, 1997 administrative closure was premature because the insurer warned him of impending closure (for alleged failure to seek medical treatment for more than thirty days) *less* than thirty days after he in fact sought medical treatment for his compensable condition. *See* ORS 656.268(1)(b);[2] OAR 436-030-0034 (WCD Admin. Order 96-052).[3] In addition, because the administrative closure rules allow a 14-day period to respond to a warning letter, and that time period

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[1] Claimant also argues that the ALJ erred in excluding Proposed Exhibit 20, a March 10, 1998 report from claimant's attending physician. We agree with the ALJ that the disputed document was properly excluded because it was not part of the reconsideration record. *See* ORS 656.283(7). *See Brian L. Schmitt*, 49 Van Natta 1583, 1585 (1997).

[2] ORS 656.268 provides, in relevant part:

"(1) * * * Claims shall not be closed if the worker's condition has not become medically stationary unless:

"* * * *

"(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days * * * unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

[3] OAR 436-030-0034(1) provides, in relevant part:

"A claim may be closed by the insurer or Department when the worker is not medically stationary and the worker has not sought medical care 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;

"* * * *"

only properly runs *after* a worker fails to seek treatment for 30 days, claimant contends that closure before October 5, 1997 would not comply with the rules.[4] Claimant also argues that the insurer's processing was improper because the warning letter issued before claim acceptance, but the administrative closure rules apply only to accepted claims.

We need not determine whether the insurer's claim processing or the Department's initial administrative closure was proper, because even if these procedures were improper, that would not aid claimant's cause. Claimant requested reconsideration of the September 30, 1997 Determination Order, raising both premature closure and medically stationary date as among the contested issues. The insurer also raised the medically stationary date as an issue. On reconsideration, the medically stationary date was revised but continued to be a date prior to the closure. Our review is of the Order on Reconsideration. ORS 656.268(6)(g) and 656.319(4). Because the Order on Reconsideration closed the claim based on a finding that claimant's condition was medically stationary, the merits of the premature closure issue remain irrespective of the procedural closure issue, and claimant was medically stationary at claim closure (as explained by the ALJ).[5] *See Mark E. Cooper*, 47 Van Natta 2223, 2224, n. 3 (1995) (cited in *Tat Hueng*, 50 Van Natta 2205 (1998)).

The worksheet accompanying the September 30, 1997 Determination Order indicates that the claim was closed under OAR 436-030-0034(1) and that claimant was not medically stationary on August 26, 1997 (when the insurer requested closure for alleged failure to seek medical treatment for more than thirty days). But the Order on Reconsideration modified the Determination Order, stating that the Determination Order was

> "amended to reflect the medically stationary date of August 22, 1997 per the attending physician report. As a result, the claim closure of September 30, 1997 was not premature pursuant to OAR 436-030-0035(2) and (4)."[6] (Ex. 19-2).

Thus, although the claim was initially closed administratively, closure was based on claimant's *medically* stationary status as of reconsideration.[7] Moreover, because we agree with the ALJ that claimant was

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[4] *See* note 3, *supra*.

[5] However, we note that claimant is correct that the insurer's August 25, 1997 warning letter incorrectly asserted that claimant had failed to seek medical treatment for more than thirty days. The record indicates that claimant sought treatment for his low back on August 22, 1997, only twenty-six days after a prior doctor's appointment. (Exs. 3, 4, 6). The record also indicates that the insurer did not receive the August 25, 1997 chartnote until September 25, 1997 -- after issuance of the August 27, 1997 warning letter. (*See* Exs. 6, 7).

[6] OAR 436-030-0035, entitled "Determining Medically Stationary Status," provides in pertinent part:

"(1) A worker's compensable condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

"(2) When there is a conflict in the medical opinions as to whether or not a worker's compensable condition is medically stationary, more weight shall be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

"* * * *

"(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions shall govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established pursuant to section (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date."

[7] Considering the apparent procedural error in the initial administrative closure, (*see* n.5, *supra*) and the medical evidence, we conclude that the Department properly modified the Determination Order on reconsideration. *See e.g., Estella Rogan*, 50 Van Natta 205, n. 4 (1998) (The Department was authorized to address premature closure on reconsideration even though parties did not expressly raise the issue). Moreover, because the "medically stationary/merits" question was an issue "arising out of" the reconsideration order, it was within the ALJ's purview at hearing. *See* ORS 656.268(8).

medically stationary on August 22, 1997 (based on the attending physician's uncontradicted opinion that claimant's lumbar strain condition had resolved on that date), we also agree that the claim was not prematurely closed.[8]

ORDER

The ALJ's order dated August 21, 1998, as reconsidered September 9, 1998, is affirmed.

[8] *Compare Paniagua v. Liberty Northwest, 122 Or App 288 (1993), on remand,* 46 Van Natta 55 (1994) (Board erred in finding the claimant medically stationary and upholding claim closure based on the medical evidence, where administrative closure was procedurally improper, the insurer never contended that the claimant was medically stationary, and the record did not indicate that the claimant was in fact medically stationary at claim closure).

February 22, 1999 Cite as 51 Van Natta 306 (1999)

In the Matter of the Compensation of
ANNA R. HEATON, Claimant
WCB Case No. 96-03646
ORDER ON REMAND
Martin L. Alvey, Claimant Attorney
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its August 5, 1998 order, the court has vacated our prior order that affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's right knee and ankle injury claim. Noting that SAIF has subsequently accepted claimant's claim, the court has vacated our order and remanded "with instructions to vacate the administrative law judge's decision upholding SAIF's denial of the claim."

In accordance with the court's mandate, the ALJ's order dated August 23, 1996 is vacated. We now proceed to resolve an issue that has arisen on remand regarding claimant's request for an attorney fee award for her counsel's services previously rendered before the Hearings Division and on Board review.

We provide the following summary of the procedural history of this case. By an opinion and order dated August 23, 1996, an ALJ upheld SAIF's denial of claimant's right knee and ankle injury claim. On June 24, 1997, we adopted and affirmed that order. *Anna R. Heaton,* 49 Van Natta 823 (1997). Claimant appealed our order. On April 23, 1998, while claimant's appeal was pending at the court, SAIF accepted claimant's injury claim. Claimant moved the court for a decision designating her as the prevailing party on judicial review and for a remand to the Board to allow it to make an award of attorney fees for services before the Board and the ALJ. On August 5, 1998, the court issued an "Order Vacating and Remanding." Specifically, the court provided:

> "In light of SAIF's acceptance of petitioner's claim, the court on its own motion vacates the Workers' Compensation Board's order upholding SAIF's denial of the claim and remands to the Board with instructions to vacate the administrative law judge's decision upholding SAIF's denial of the claim.
>
> "Petitioner's motion for designation as prevailing party is allowed."

On August 10, 1998, claimant's attorney petitioned the court for attorney fees in the amount of $3,105 for services rendered before the court. On December 7, 1998, the court issued an appellate judgment awarding claimant, *inter alia,* attorney fees of $3,105.

On remand, claimant's attorney requests an assessed attorney fee award for services rendered at the Board and Hearings levels, contending that he is entitled to such a fee under ORS 656.386(1).[1] We disagree.

Attorney fees may be awarded in workers' compensation cases only as expressly authorized by statute. *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Contrary to claimant's attorney's contention, he is not entitled to an attorney fee award under ORS 656.386(1), nor is he entitled to a fee under ORS 656.388(1),[2] the only other statute that might possibly provide for an assessed fee under the circumstances of this case. In this regard, we find *Marco Aguiar*, 40 Van Natta 85 (1988), *aff'd Aguiar v. J.R. Simplot Co.*, 94 Or App 658 (1989), controlling.

In *Aguiar*, we initially found that the claimant's proposed surgery was not reasonable and necessary, that the claim was not prematurely closed, and that the claimant had suffered no permanent disability. On appeal, the court reversed on the first two issues and found that, given its decision that the claim was prematurely closed, the permanent disability issue was rendered moot. The court remanded "with instructions to reinstate the referee's[3] order setting aside [the carrier's] partial denial of surgery and award of attorney fees and to rescind the May 15, 1984, determination order as prematurely closed." *Aguiar v. J.R. Simplot Co.*, 87 Or App 475 (1987) (footnote added). Thereafter, the claimant submitted a petition for attorney fees with the Court of Appeals. Finding the petition untimely filed, the court issued an order denying it.

Subsequently, we issued an order on remand and followed the court's instructions, including reinstating the Referee's award of attorney fees for services at hearing, but we declined to award additional attorney fees for services at subsequent levels of review. *Marco Aguiar*, 40 Van Natta 3 (1988). The claimant requested reconsideration, contending that he was entitled to assessed attorney fees for prevailing finally against the partial denial "at the Board level." We disagreed.

We found that the claimant did *not* finally prevail at the Board level; instead, he had finally prevailed before the Court of Appeals. 40 Van Natta at 86. Therefore, under ORS 656.386(1), we reasoned that the court was authorized to allow a reasonable attorney fee for the services rendered by the claimant's counsel in overturning the denial before the court. In fact, we noted that the claimant had petitioned for such fees, and his petition had been denied as untimely filed.

We also rejected the claimant's reliance on ORS 656.388(1) in support of his claim for attorney fees. We found that ORS 656.388(1) expressly applied to those cases "in which a claimant finally prevails after remand." We reasoned that the claimant did not finally prevail *after remand*, but rather he finally prevailed *before* the Court of Appeals. Therefore, we found that ORS 656.388(1) did not apply to authorize an attorney fee. 40 Van Natta at 87.

On appeal, the claimant argued that, pursuant to ORS 656.388(1), we should have awarded reasonable attorney fees for each level of review through remand. The court disagreed, finding that it had decided the merits of the substantive questions in its previous order. The court held that the

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

"(a) In all cases involving denied claims where a claimant finally prevails against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. * * * "

[2] ORS 656.388(1) provides, in relevant part:

"In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law Judge, board, or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum as authorized under ORS 656.307(5), 656.308(2), 656.382 or 656.386."

[3] At that time, ALJs were designated as "Referees."

claimant had finally prevailed when the case was previously before it. The court determined that it remanded to the Board only for the ministerial implementation of its decision, there being no matters on which the claimant finally could prevail after remand. Therefore, the court held that we had properly determined that we had no authority to award attorney fees to the claimant under ORS 656.388(1). *Aguiar*, 94 Or App at 660.

Here, like *Aguiar*, claimant is not entitled to an attorney fee under ORS 656.388(1) because the court's order left no substantive matters to be decided on remand. Instead, the court vacated our order and remanded "with instructions to vacate the administrative law judge's decision upholding SAIF's denial of the claim." Thus, as in *Aguiar*, the court simply remanded to the Board for the ministerial implementation of its decision; therefore, claimant did not finally prevail *after remand*, which is the prerequisite for an attorney fee award under ORS 656.388(1). Accordingly, claimant is not entitled to an attorney fee award under that statute.

By the same token, claimant is not entitled to an attorney fee award under ORS 656.386(1). Like *Aguiar*, claimant did not finally prevail against a denial in a review by the Board, which would authorize us to award an attorney fee under ORS 656.386(1). Instead, claimant finally prevailed in an appeal to the Court of Appeals. The court awarded an attorney fee and remanded the case to us with express and unequivocal instructions "to vacate the administrative law judge's decision upholding SAIF's denial of the claim." Under such circumstances, we are not authorized to award an attorney fee.

Claimant argues that the court order did just what she requested in that it: (1) awarded $3,105 in attorney fees for services performed at the court level; and (2) remanded the case to the Board to vacate the ALJ's order *and* award attorney fees for services at the hearings and Board levels. We disagree.

We acknowledge that the court has awarded attorney fees for services rendered at the court level and remanded the case with instructions to vacate the ALJ's order upholding SAIF's denial of the claim. But the court has provided no instructions regarding any attorney fee award. When it is the court's intention that the Board will award an attorney fee for a claimant's counsel's services at hearing or on review, the court has previously provided such instructions. *Compare Donald Converse*, 50 Van Natta 2067 (1998) (court remanded on merits and granted the claimant a specified attorney fee for services rendered on judicial review, conditioned on the claimant prevailing on remand; Board found the claim compensable on remand and awarded attorney fees for services at hearing and on review, in addition to the specified attorney fee awarded by the court); *Gene H. Gosda*, 50 Van Natta 2279 (1998) (same). In light of the statutory scheme, case precedent, and the absence of further instructions from the court, we are without authority to award additional attorney fees. ORS 656.386(1); 656.388(1); *Aguiar*, 40 Van Natta at 86-87; *Aguiar*, 94 Or App at 660.

Accordingly, consistent with the court's mandate, the ALJ's order dated August 23, 1996, that upheld SAIF's denial is vacated. The claim is remanded to SAIF for processing in accordance with law.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL S. KALETA, Claimant
WCB Case Nos. 98-03898 & 98-02289
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (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 denial of responsibility for claimant's bilateral carpal tunnel syndrome; (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for the same condition; and (3) assessed an attorney fee under ORS 656.307(5). On review, the issues are responsibility and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant worked for Pardue Restoration (insured by SAIF) from 1994 to September 1997. Pardue then "loaned" claimant to Davidson's Masonry (insured by Liberty). On October 20, 1997, claimant returned to work at Pardue; on that same date, claimant sought treatment for the first time for bilateral wrist pain. Claimant was diagnosed with bilateral carpal tunnel syndrome.

Applying the last injurious exposure rule, the ALJ found SAIF/Pardue initially responsible because claimant first sought treatment while working for that employer. *See Timm v. Maley*, 125 Or App 396, 401, *rev den* 319 Or 81 (1994) (if a claimant receives treatment for a compensable condition before experiencing time loss, the date the claimant received treatment for the compensable condition is considered the "onset of disability"). The ALJ further found that the medical evidence failed to establish that work at Liberty/Davidson's was the sole cause of claimant's carpal tunnel syndrome or that it was impossible for claimant's work at Pardue on October 20, 1997 to have contributed to the condition. Consequently, citing *FMC Corp. v. Liberty Mutual Ins. Co.*, 70 Or App 370, 373, *mod* 73 Or App 233, *rev den* 299 Or 203 (1985), the ALJ decided that SAIF/Pardue could not shift responsibility to Liberty/Davidson's.

On review, SAIF contends that the last injurious exposure rule should not apply because it proved "actual causation." According to SAIF, because the medical evidence shows that work at Davidson's is the major contributing cause of claimant's bilateral carpal tunnel syndrome, Liberty is the responsible carrier.

Several physicians provided opinions concerning the cause of claimant's condition. Examining neurologist, Dr. Gardner, reported that work at Davidson's was the "most likely proximate cause" because claimant's "symptom onset appeared to coincide" with his work at Davidson's. (Exs. 16-5). Dr. Gardner also thought that the single day of work at Pardue was not a "proximate cause." (*Id.*) Dr. Gardner subsequently agreed with a letter stating that "the work activities at Pardue Restoration on October 20, 1997, did not actually contribute pathologically" to the carpal tunnel syndrome. (Ex. 23).

Treating osteopath, Dr. Witzcak, first indicated that he agreed with most of Dr. Gardner's report but he could not "pinpoint precisely whether the work exposure @ Pardue or Davidson was > 51% responsible." (Ex. 24). Dr. Witzcak then reported that "the major contributing cause of [claimant's] bilateral carpal tunnel syndrome is a result of the years of exposure while employed at Pardue Restoration." (Ex. 25-1). Based on claimant's report that he had carpal tunnel symptoms before working at Davidson's, Dr. Witczak thought that the condition preexisted his employment at Davidson's and further stated that claimant's "work at Davidson did aggravate a pre-existing condition." (*Id.* at 2).

Dr. Kirschner, neurologist, performed a record review. According to Dr. Kirschner, because claimant sought treatment after working for a short period at Pardue, that employment "is a factor contributing to causation of his symptoms." (Ex. 25A-2).

Finally, Dr. Weller, consulting physician, indicated that "claimant's work at Pardue from 1994 and subsequent work at Davidson's Masonry, which lasted approximately one month, would be the major contributing cause of his carpal tunnel condition." (Ex. 26-1). Dr. Weller further indicated that the work at Davidson's "probably caused a pathological worsening and is the major contributing cause" and the single day of work at Pardue "did not actually contribute pathologically" to the condition. (*Id.* at 2).

After examining the medical opinions, we disagree with SAIF that the ALJ improperly applied the last injurious exposure rule because the record establishes the "actual cause" of claimant's carpal tunnel syndrome. Because the medical opinions show that the major contributing cause of claimant's condition was successive employments, we agree with the application of the last injurious exposure rule. *See Safeco Ins. Co. v. Victoria*, 154 Or App 574, 577-78 (1998) (Board erred in assigning responsibility according to "actual causation" instead of the last injurious exposure rule when record showed that job activities at successive employments both contributed to the claimant's condition).

We also agree with the ALJ that, because claimant sought first sought treatment while working for Pardue, SAIF is initially responsible. *Timm*, 125 Or App at 401. Only Dr. Gardner and Dr. Weller assess contribution between claimant's 1994-97 employment with Pardue, Davidson's, and the subsequent single day of work at Pardue. Because both physicians indicate that the October 20 employment at Pardue did not "pathologically worsen" claimant's condition, we find their opinions sufficient to establish that prior employment with Davidson and the 1994-97 exposure with Pardue was the sole cause of claimant's carpal tunnel syndrome. Thus, responsibility shifts from SAIF to Liberty/Davidson's. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997).

We now turn to whether Liberty/Davidson's may shift responsibility to SAIF, as the carrier for claimant's employment with Pardue between 1994-97. Because we find no evidence that this exposure was the sole cause of claimant's carpal tunnel syndrome condition or that it was impossible for claimant's employment with Liberty/Davidson's to have contributed to that condition, responsibility remains with Liberty/Davidson's. *Id.*

Attorney Fees

The ALJ assessed an attorney fee of $3,000 pursuant to ORS 656.307(5). On review, SAIF continues to assert that claimant's attorney is limited to an attorney fee of $1,000, as provided by ORS 656.308(2)(d).

We first note that, because we have found that SAIF is not responsible, it is not liable for the attorney fee awarded by the ALJ. Furthermore, we agree with SAIF that ORS 656.307(5) is not the appropriate statute for awarding an attorney fee.

ORS 656.307(5) provides:

> "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim."

ORS 656.308(2)(d) provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

When construing statutes, our task is to ascertain the intent of the legislature when enacting the provisions in question. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12 (1993). We begin with the text and context of the statutes, because the best evidence of legislative intent is the statute itself. *Id.* at 610.

ORS 656.307(5) first states that the "claimant shall be joined in any proceeding *under this section*" and, if the claimant "appears *at any such proceeding*," the ALJ may award an attorney fee under certain circumstances. (Emphasis added.) Because subsection (5) is within the section addressing cases coming under ORS 656.307, we find that the language referring to "proceedings under this section" means those cases that are conducted before an ALJ after the Department has issued an order designating which carrier shall pay the claim. *See* ORS 656.307(2). *Accord Dean Warren Plumbing v. Brenner*, 150 Or App 422 (1997) (ORS 656.307(5), rather than ORS 656.308(2)(d), found to be the appropriate statute for awarding an attorney fee in "307" proceeding).[1]

In contrast, ORS 656.308(2)(d) allows an attorney fee when there is active and meaningful participation "in finally prevailing against a responsibility denial." Although subsection (2)(d) is within the same section as subsection (1), which addresses responsibility for "new compensable injuries," subsection (2)(d) does not specifically refer or limit itself to responsibility proceedings involving "new compensable injuries." Rather, the statute applies when the attorney prevails "against a responsibility denial." Consistent with such general language, we find that the statute is not limited to responsibility proceedings under ORS 656.308(1).

Here, there was no "307" order. Thus, ORS 656.307(5) does not apply. Claimant's attorney, however, did finally prevail on Board review against Liberty's responsibility denial. Because counsel also appeared and actively and meaningfully participated in the proceeding, we conclude that ORS 656.308(2)(d) is the proper statute for awarding an attorney fee.

Claimant's attorney is entitled to no more than $1,000 "absent a showing of extraordinary circumstances." Although claimant's counsel does not explicitly assert "extraordinary circumstances," after reviewing this record, we find no extraordinary circumstances that justify a fee greater than $1,000. Two carriers were joined in the hearing; the hearing transcript was 56 pages long and three witnesses testified. There were 26 exhibits; at least one was generated by claimant's attorney. On review, claimant submitted a seven-page respondent's brief.

Under such circumstances, we award claimant's attorney $1,000. *See Terry L. Vanyi*, 50 Van Natta 1016 (1998); *Steve H. Salazar*, 48 Van Natta 2389 (1996). Claimant is not entitled to an attorney fee for his counsel's services on review regarding the attorney fee and responsibility issues. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Liberty Northwest Ins. Corp. v. Gordineer*, 150 Or App 136 (1997) (maximum award under ORS 656.308(2)(d) for prevailing over a responsibility denial is $1,000 for all levels of review, absent a showing of extraordinary circumstances).

ORDER

The ALJ's order dated August 21, 1998 is reversed. SAIF's denial of responsibility is reinstated and upheld. Liberty's denial is set aside and the claim is remanded for processing according to law. In lieu of the ALJ's attorney fee award of $3,000, claimant's attorney is awarded a fee of $1,000, payable by Liberty.

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[1] We disagree with the ALJ's reading of *Brenner* as holding that "the court has limited the application of ORS 656.308(2)(d) to '308' cases where one of the involved insurers has previously accepted the condition currently at issue." Instead, we find *Brenner's* holding to be limited to cases where a "307" order has issued. Because there is no "307" order in this case, we find *Brenner* to be of limited help here.

In the Matter of the Compensation of
JOHN P. O'CONNOR, Claimant
WCB Case No. 98-01269
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded an assessed fee of $4,000 pursuant to ORS 656.386(1). SAIF also moves to remand regarding the attorney fee issue. On review, the issue is attorney fees and remand.

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

The ALJ awarded claimant's attorney an assessed fee of $4,000. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in determining the amount of the attorney fee.[1] SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award.

We considered similar arguments 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 Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

Here, however, the ALJ simply ordered SAIF to pay "a reasonable attorney fee pursuant to ORS 656.386(1) in the amount of $4,000." Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), we agree with SAIF that the ALJ did not provide reasoning sufficient for review. *See Carol E. Brown*, 51 Van Natta 58 (1999). Nevertheless, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation 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 2330.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The record contains no statement of services documenting the time claimant's attorney spent on the case. The issue was compensability of claimant's low back strain. The hearing lasted 2 hours and generated 74 pages of transcript. Claimant testified on his own behalf. SAIF presented the testimony of one witness. The record contains 43 exhibits, one of which was submitted by claimant's attorney. There was one deposition, lasting 43 minutes and generating 26 pages of transcript.

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[1] SAIF does not contend that the ALJ's attorney fee award was excessive.

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. Because claimant's low back 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the nature of the proceedings (including the deposition), the value of the interest involved, and the risk that counsel may go uncompensated.[2]

ORDER

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

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[2] 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, *rev den* 302 Or 35 (1986).

February 22, 1999 Cite as 51 Van Natta 313 (1999)

In the Matter of the Compensation of
GUILLERMO RUVALCABA, Claimant
WCB Case No. 98-04288
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's current right shoulder condition. On review, the issue is the procedural validity of the denial. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable right shoulder injury on April 21, 1997, accepted as a nondisabling right trapezius strain on May 28, 1997. The insurer later reclassified the claim to "disabling" in April 1998. On May 13, 1998, the insurer amended its acceptance to include a right trapezius muscle strain as a "combined condition." (Ex. 23).

That same day, the insurer issued a denial of the "combined condition" on the ground that a preexisting condition was the major contributing cause of the combined condition, disability and medical treatment. (Ex. 24). The denial further specified that claimant's "current condition" was unrelated to the accepted injury and was entirely due to either or both the preexisting condition and/or subsequent work exposures. Finally, the denial alleged that subsequent work exposures independently contributed to a pathological worsening of claimant's condition. *Id.* Claimant requested a hearing.

On July 8, 1998, a Determination Order closed the claim. No permanent disability was awarded. (Ex. 27).

At hearing, claimant challenged the procedural validity of the insurer's denial. The ALJ agreed that it was procedurally invalid. The ALJ reasoned that denial was issued as a combined condition denial pursuant to either ORS 656.262(6)(c) and/or ORS 656.262(7)(b). The ALJ found, however, that the medical evidence did not establish the presence of a "combined condition." The ALJ acknowledged the insurer's acceptance of a combined condition. But the ALJ found that the amended acceptance of a combined condition was done for the sole purpose of satisfying the requirements governing preclosure combined condition denials. Under these circumstances, the ALJ concluded there was not a voluntary acceptance of a combined condition prior to the denial. Because there was no combined condition, the ALJ concluded that ORS 656.262(6)(c) and ORS 656.262(7)(b) were inapplicable. That being the case, the ALJ found the denial procedurally invalid.

Citing *Tracey A. Blamires*, 50 Van Natta 1793 (1998), which issued subsequent to the hearing in this matter, the insurer asserts on review that the ALJ's procedural analysis was incorrect because there is no longer a requirement that a carrier accept a "combined condition" before issuing a combined condition denial. Further, the insurer contends that the ALJ incorrectly determined that there was no combined condition and, even assuming that the ALJ's determination was correct, the ALJ failed to analyze the other bases for its denial.

We agree with the insurer that, pursuant to *Blamires*, a carrier is no longer required to have accepted a "combined condition" before it can issue a combined condition denial. 50 Van Natta at 1796. Therefore, we disagree with the ALJ's determination that acceptance of a combined condition must have preceded the insurer's denial. Having said this, we nevertheless agree with the ALJ that the medical evidence does not establish the presence of a combined condition. In fact, Dr. Price, an examining physician, specifically stated that there was no indication that a preexisting condition combined with the April 21, 1997 injury. (Ex. 29-2). Accordingly, to the extent that the insurer's denial attempted to deny a "combined condition," it is invalid.

The insurer correctly observes, however, that other grounds for the denial were listed in the denial letter. The denial asserted that the "current condition" was unrelated to the compensable injury and that subsequent work exposures independently contributed to a pathological worsening of claimant's condition. Those assertions notwithstanding, the record does not establish that a subsequent work exposure contributed to claimant's condition. Moreover, the insurer's current condition denial issued prior to claim closure.

Generally preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid. *See Connie L. Birrer*, 51 Van Natta 163 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition). Here, the medical evidence does not "unequivocally indicate" this claimant's current condition when denied was unrelated to the accepted trapezius strain. To the contrary, Drs. Price and Nank, who performed an insurer-arranged medical examination, reported that claimant "has cervicodorsal impairment as a result of the April 21, 1997, incident." (Ex. 13-10). In addition, the examiners reported the absence of a diagnosed condition "although contusion or strain/sprain might be suspected from the work activities described ." *(Id.)* Under the circumstances, we are unable to find that the medical evidence unequivocally indicates the absence of any casual relationship between the accepted injury and claimant's current condition.

The insurer also argues that it denied conditions severable from the accepted right shoulder condition. As support, the insurer cites the November 3, 1997 medical report from examining physicians, Drs. Price and Nank. (Ex. 13). It asserts that three of the conditions diagnosed are unrelated to the accepted trapezius condition. (Reply Brief p. 2). These are a "symptom complex," which includes bilateral hand numbness, upper limb swelling, visual blurring, chest pain, knee and ankle pain. (Ex. 13-9). The other conditions are cervical spondylosis and "other unrelated conditions such as service-related disability, hypertension, obesity." *Id.*

We do not find the insurer's argument persuasive. The allegedly unrelated diagnoses are not mentioned in the denial. Moreover, a listing of diagnoses in an "IME" is not a claim. *Sharon Evans*, 42 Van Natta 227 (1990); *Alvin Despain*, 40 Van Natta 1823 (1988). Indeed no claim for "symptom complex," cervical spondylosis, service related disability, hypertension or obesity has been made. *See* ORS 656.262(7)(a) (listing requirements for "new medical condition" claims). The insurer's denial, which it alleges was based on the diagnoses listed in the November 3, 1997 medical report, was premature and, therefore, invalid. *Shannon M. Evans*, 42 Van Natta at 228.

Thus, even if the denied conditions are severable from the accepted right shoulder condition, the insurer's denial was still procedurally invalid. Accordingly, we affirm.

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

ORDER

The ALJ's order dated September 28, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

February 23, 1999 Cite as 51 Van Natta 315 (1999)

In the Matter of the Compensation of
JEFFREY T. BLANCHARD, Claimant
WCB Case No. 98-05663
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Otto's order that found that claimant's bilateral carpal tunnel syndrome claim was prematurely closed. On review, the issue is premature closure.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated September 30, 1998 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer.

Board Member Moller dissenting.

The majority finds Dr. King's opinion regarding claimant's disputed medically stationary status more persuasive than that of Dr. Rabie. I disagree, because the record indicates that Dr. Rabie was in a much better position to evaluate claimant's compensable bilateral carpal tunnel syndrome (CTS) condition than was Dr. King.

Dr. Rabie began treating claimant for his compensable condition on May 21, 1997. He saw claimant on numerous occasions in May, June, July, August, September, October, November, and December 1997 and in January, February, March, and April 1998. Dr. Rabie also provided follow-up care after claimant's December 9, 1997 left carpal tunnel release surgery and after his March 10, 1998 right carpal tunnel release surgery. On April 28, 1998, Dr. Rabie declared claimant medically stationary and released him to his regular work.

Dr. King, on the other hand, first examined claimant on April 15, 1998. A May 8, 1998 chart note recommending 6 more weeks of physical therapy is the only indication that Dr. King may have seen claimant more than once. There is no evidence that Dr. King had claimant's prior treatment records or that he was aware of the extent and longevity of claimant's prior treatment.

In any event, Dr. King did not see claimant until after claimant had undergone ten months of treatment, including two surgeries, for his bilateral CTS. Dr. King's limited contacts with claimant contrast sharply with Dr. Rabie's long treatment history. Under these circumstances, based on Dr. Rabie's advantage as claimant's treating physician, I would rely on his opinion that claimant was medically stationary on April 28, 1998 and conclude that the claim was not prematurely closed.

February 23, 1999 Cite as 51 Van Natta 316 (1999)

In the Matter of the Compensation of
MARCELLA L. BROOKS, Claimant
WCB Case No. 97-07653
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order[1] that: (1) found that the Board's remand for reconsideration of the ALJ's prior order for consideration of the insurer's amended denial was "moot" because of the insurer's rescission of its denial; and (2) awarded an assessed attorney fee of $750. In her brief, claimant contends that she is entitled to a greater attorney fee.[2] On review, the issues are propriety of the ALJ's order and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In 1995, the insurer accepted "bilateral forearm tendonitis." In September 1997, the insurer revoked the acceptance and denied the claim. Claimant proceeded to hearing before ALJ Podnar.

At hearing, the insurer's attorney moved to amend its denial to include claimant's current condition. The ALJ denied the motion on the basis that the insurer was attempting to issue a new and distinct denial rather than amend its original denial. The ALJ also set aside the insurer's "back-up" denial.

On review, the Board issued an order affirming that portion of the ALJ's order that set aside the "back-up" denial. *Marcella L. Brooks*, 50 Van Natta 1006 (1998). The Board further decided that "the insurer was not precluded from amending its denial at hearing" and found that claimant's objection to the amendment constituted a request to continue the hearing. Because "original authority to consider such procedural motions rests with the ALJ," the Board remanded the case "to the ALJ for consideration of claimant's motion to continue the hearing based on the insurer's amended denial." Thus, the Board vacated "the portion of the ALJ's order that denied the insurer's motion to amend its denial."

CONCLUSIONS OF LAW AND OPINION

On remand, the ALJ found:

"On August 28, 1998, a conference call was held with claimant's counsel, defense counsel and the undersigned administrative law judge.

"During this conference call, defense counsel advised that defendant no longer wished to amend the denial.

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[1] Although the ALJ's order is captioned "Opinion and Order on Reconsideration," we treat is as an "Opinion and Order on Remand."

[2] Before submitting a brief, claimant filed a cross-request for review "for a frivolous Insurer's Request for Review." Because claimant does not request or discuss sanctions in her brief, we do not consider claimant as pursuing this issue on review. Even if we considered sanctions as an issue on review, we would reject such a request based on our decision to reverse a portion of the ALJ's order.

"This rendered the remand moot.

"* * * * *

"Based upon the conference call and correspondence, I conclude that defendant waives any entitlement to amend the previously litigated denial and waives any challenge to any requests for hearing claimant may make relative to claimant's requests to amend the acceptance.

"Thus, the Opinion and Order of December 30, 1997 shall be incorporated herein by reference and republished as written.

"Because of this remand issue, claimant's counsel was required to perform additional services on behalf of his client. I find that a reasonable fee for those services is $750."

The insurer first contends that, by republishing the original order, the ALJ's order on remand is "both unnecessary and wrong." Although the insurer agrees with the ALJ that the "remand is moot," the insurer contends that there is no statutory basis for an attorney fee. Finally, the insurer argues that, if claimant is entitled to an assessed attorney fee, the ALJ's award is excessive.

Claimant "agrees" that the republication "is probably not necessary in this case." Claimant, however, defends the ALJ's attorney fee award, contending that it is appropriate under ORS 656.386(1) because the insurer rescinded its denial before hearing.

We agree with the parties that the portion of the ALJ's order on remand republishing the original Opinion and Order should be reversed. By incorporating and republishing the original order, the ALJ's order on remand contradicts the Board's order finding that the insurer successfully amended its denial. Instead, we find that, based on the Board's order, when the case was before the ALJ on remand, the insurer's denial had been amended. By stating that it "no longer wished to amend the denial," the insurer in effect rescinded the amended denial of claimant's current condition.

Furthermore, the rescission occurred before the ALJ rendered an order. Consequently, we agree with claimant that he is entitled to an assessed attorney fee under ORS 656.386(1) if counsel was instrumental in obtaining the rescission.[3] Because claimant's counsel participated in the discussion resulting in the insurer's rescission, we conclude that claimant is entitled to an assessed attorney fee.

In determining a reasonable attorney fee under OAR 438-015-0010(4), we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

The issue before the ALJ on remand initially was for consideration of claimant's motion to continue the hearing based on the insurer's amended denial. Although claimant's attorney did not provide a written statement of services at hearing, on review he estimates that he expended 4 hours on the remanded case. There was no hearing and no record was developed.

Because the current condition denial was rescinded, claimant is entitled to workers' compensation benefits; it appears that the value of the interest involved and the benefit secured for claimant are average. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were asserted. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated had the insurer decided not to rescind its denial.

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[3] The relevant portion of ORS 656.386(1) provides:

"In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed."

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services in rescinding the current condition denial is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (based on claimant's attorney's estimate), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated. Claimant's counsel is not entitled to an attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 24, 1998 is reversed in part and affirmed in part. That portion of the order republishing the ALJ's original Opinion and Order is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
NICHOLAS L. DAVISCOURT, Claimant
WCB Case No. C9-00179
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

On January 21, 1999, 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.

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). OAR 438-009-0022(3)(k) 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)."

Here, claimant is unrepresented and, thus, the parties may not waive the 30-day period. *See* ORS 656.236(1)(b). Nevertheless, the box on the first page of the CDA indicating that the parties wish to waive the "30-day" cooling off period has been checked "yes." The body of the CDA contains no corresponding paragraph confirming the parties' intent.

We are persuaded that the statement on the box on the first page of the CDA providing that the parties wish to waive the 30 day waiting period was inadvertently checked "yes."[1] Thus, we do not interpret the agreement as attempting to waive the 30-day period. In any case, the 30-day "cooling-off" period has now expired. Accordingly, we have proceeded with our review of the CDA.

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' CDA is approved.

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

IT IS SO ORDERED.

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[1] We note that a letter from SAIF to claimant accompanied the CDA, which contains a statement suggesting that the parties did not intend to waive the 30-day period.

In the Matter of the Compensation of
KENNETH A. MEYER, Claimant
WCB Case No. 97-08075
ORDER ON RECONSIDERATION
Geoffrey G. Wren, Claimant Attorney
Lane, Powell, et al, Defense Attorneys

On December 31, 1998, we abated our December 7, 1998 Order on Review to consider claimant's request for reconsideration. In our December 7, 1998 order, we reversed an Administrative Law Judge's (ALJ's) award of: (1) procedural temporary total disability (TTD) compensation commencing February 2, 1998; and (2) an "out-of-compensation" attorney fee. On reconsideration, claimant contends that our decision on this issue was an advisory opinion and should be withdrawn. The self-insured employer has filed a response to claimant's argument, and we are now ready to proceed with our reconsideration.

In reversing the ALJ's award of procedural TTD, we concluded that the employer strictly complied with ORS 656.325(5)(b) and OAR 436-060-0030(6).[1] Thus, we reasoned that the employer had the authority to terminate claimant's procedural TTD commencing February 2, 1998, the date claimant was released to light duty work as a "grader trainer".

On reconsideration, claimant submits a copy of the "post-ALJ order" Department's October 7, 1998 Order on Reconsideration awarding claimant substantive temporary disability benefits from July 8, 1997 through July 13, 1997, and from July 22, 1997 through April 21, 1998, less time worked.[2] In light of this substantive temporary disability award, claimant asserts that "there was no time loss benefit claimant stood to gain from issuance of the Board's order in this case regarding procedural time loss." *See Lebanon Plywood v. Seiber*, 113 Or App 651 (1992) (neither the Hearings Division nor the Board has the authority to impose an overpayment by awarding procedural temporary disability benefits other than those that are substantively determined at the time of claim closure). Thus, claimant reasons that our award of procedural time loss was an advisory opinion. *See Scott C. Clark*, 47 Van Natta 133 (1995) (where controversy over compensability is rendered moot, Board declines to issue advisory opinion addressing that issue). *Accord Dwight M. Page*, 48 Van Natta 972 (1996); *Gerald J. Dahl*, 47 Van Natta 1055 (1995).

The employer opposes claimant's motion to vacate the procedural TTD ruling in our December 7, 1998 order. The employer notes that "[t]he decision by the Board to reverse the ALJ's award of procedural temporary disability is not inconsistent with the Order on Reconsideration's award of substantive temporary disability for the same period of time." Thus, the employer reasons that the award of substantive TTD does not preclude the Board from reversing the ALJ's award of procedural TTD.

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[1] 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).

[2] Claimant asserts that the October 7, 1998 reconsideration order was not appealed and has become final as a matter of law; and the employer does not challenge this assertion. In any event, for purposes of administrative efficiency, we will generally give precedential effect to a non-final litigation order. *See Elmer F. Knauss*, 47 Van Natta 826, *on recon* 47 Van Natta 1064 (1995). Furthermore, while the October 7, 1998 reconsideration order is not part of the record developed at hearing, it is an appropriate subject for our administrative notice. *See Brian M. Eggman*, 49 Van Natta 1835 (1997) (we may take administrative notice of agency orders involving the same claimant); *Rodney J. Thurman*, 44 Van Natta 1572 (1994) (we may take administrative notice of any fact that is capable of accurate and ready determination by resort to sources whose accuracy cannot readily be questioned).

We agree with the employer's rationale and decline to vacate our procedural TTD ruling. Our December 7, 1998 order did not create an overpayment because it reversed the ALJ's award of procedural TTD. Conversely, affirming the ALJ's award would not have created an overpayment because the ALJ's procedural TTD award was consistent with the substantive temporary disability award. Thus, the closure award of substantive TTD does not adversely impact our authority to review the ALJ's award of procedural TTD.[3]

Accordingly, we withdraw our December 7, 1998 order. On reconsideration, as supplemented herein, we adhere to and republish our December 7, 1998 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[3] In reaching this conclusion, we emphasize that our decision has no effect on the substantive temporary disability award granted by the Order on Reconsideration. Rather, our holding is solely confined to the issue of whether claimant was procedurally entitled to temporary disability during the disputed period in question; *i.e.*, whether the employer was authorized to terminate such benefits.

In the Matter of the Compensation of
MICHAEL J. SIMPSON, Claimant
WCB Case Nos. 97-10109 & 97-08899
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Black's order that assessed an attorney fee under ORS 656.308(2)(d). On review, the issue is attorney fees.

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

The insurer denied claimant's aggravation claim, asserting:

> "Medical information in your file indicates that your current bilateral epicondylitis condition * * * [has] not worsened since your claim was previously closed. Please be advised that if in the event this aggravation is found to be compensable, it would be [the insurer's] position that your current employment * * *[*i.e.*, later employment] would be the major contributing factor toward your need for treatment and disability. Therefore, without waiving further questions of compensability, we must respectfully deny this reopening." (Ex. 74; *see* Ex. 77).

Claimant filed a claim with his later employer, SAIF's insured, and SAIF denied compensability and responsibility. Claimant requested a hearing, raising issues of compensability and responsibility.

Claimant, the insurer, and SAIF (on behalf of the later employer) appeared at the hearing. Claimant's counsel stated,

> "[T]he issues deal with the compensability of claimant's bilateral upper extremity, epicondylitis problems. Both insurers have denied compensability and responsibility." (Tr. 2).

Claimant's counsel indicated that the parties stipulated that claimant's later work activity for SAIF's insured caused either a symptomatic or pathological worsening of his compensable condition (depending on how the ALJ viewed the medical evidence). (Tr. 3). Counsel for SAIF and the insurer agreed with the stipulation. (*Id*). The ALJ asked the insurer's attorney if he had any comment on the issues. The attorney replied, "No comment, your honor." (*Id*). Counsel for SAIF then withdrew the compensability portion of SAIF's denial.

The ALJ ruled that claimant's work exposure with SAIF's insured was not the major contributing cause of a pathological worsening of his compensable condition.[1] Instead, the ALJ found that claimant had suffered a symptomatic worsening only and upheld the portion of the insurer's denial that had denied claimant's aggravation claim. The ALJ also concluded that the insurer remained responsible for claimant's compensable condition and assessed an attorney fee under ORS 656.308(2)(d),[2] to be paid by the insurer.

The insurer argues that the ALJ erred in awarding an attorney fee for services related to the responsibility issue, because the ALJ did not "reach" responsibility. According to the insurer, the ALJ would only have reached a responsibility issue if he had decided that claimant's condition worsened pathologically.[3]

But the insurer raised a responsibility issue by taking the position that a worsened condition would be SAIF's responsibility.[4] And the ALJ addressed the responsibility issue by determining that responsibility for claimant's compensable condition *remained* with the insurer.

Claimant requested a hearing to contest SAIF's and the insurer's denials and he has finally prevailed on the responsibility issue: The insurer remains responsible for claimant's compensable condition, even though it has not worsened pathologically. Under these circumstances, we agree with the ALJ that claimant is entitled to an attorney fee under ORS 656.308(2)(d) for his attorney's active and meaningful participation in the responsibility dispute at hearing. Having considered the factors in OAR 438-015-0010(4), and applying them to this case, we further agree that $1,000 is a reasonable attorney fee for claimant's services at hearing concerning the responsibility issue.

ORDER

The ALJ's order dated May 22, 1998, as reconsidered September 8, 1998, is affirmed.

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[1] The ALJ noted that claimant's position at hearing was that the insurer remained responsible for the compensable condition. (Opinion and Order, p. 4).

[2] ORS 656.308(2)(d) provides:

"Notwithstanding [statutory provisions not applicable to this case], a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. * * * *"

[3] The existence of a responsibility issue does not depend on a pathological worsening and consequent shifting of responsibility. Attorney fees are assessed under ORS 656.308(2)(d) in responsibility cases, even if the claim remains the responsibility of the insurer with the accepted claim and even-without proof of worsening. *See Pamela T. Smith*, 50 Van Natta 2162 (1998); *Darold E. Perry*, 50 Van Natta 788, 790 (1998); *Rene Kelly*; 50 Van Natta 728 (1998); *Robert H. Hannah*, 49 Van Natta 579 (1997); *Douglas H. Brooks*, 48 Van Natta 736, 739 (1996).

The insurer's case citations are inapposite: In *Dan A. Edwards*, 48 Van Natta 1693 (1996) and *Tommy J. Lively*, 48 Van Natta 1884 (1996), there were no responsibility issues because the claims were not compensable. In *Robin L. Carrillo*, 50 Van Natta 472 (1998), there was no claim against the later insurer, so there was no responsibility issue. *Id.* at n.2. In *Jill M. Miller*, 50 Van Natta 1085 (1998), the claimant's aggravation rights under the accepted claim had expired and the carrier had not denied medical services. Under the particular circumstances of the case, the claimant did not *prevail* on the responsibility issue (even though the carrier with the accepted claim remained "responsible"--because medical services were not denied and the claim was subject to the Board's Own Motion jurisdiction).

[4] The insurer argues that the responsibility portion of its denial was contingent on claimant proving either a compensable aggravation or new injury. According to the insurer, responsibility analysis was precluded because claimant proved neither and responsibility is not assessed for a "noncompensable condition." There are at least two problems with the insurer's argument. First, claimant's condition *is* compensable--and it remains the insurer's responsibility. (The insurer did not deny compensability.) Second, the insurer did not disagree with (or comment on) claimant's counsel's statement at hearing that the issues included compensability *and* responsibility. Under these circumstances, we agree with the ALJ that responsibility *was* an issue at hearing.

In the Matter of the Compensation of
GARRY L. MERCER, Claimant
WCB Case No. 97-10348
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded an assessed fee of $4,000 pursuant to ORS 656.386(1). SAIF also moves for remand to the ALJ for additional findings on the attorney fee issue. Claimant cross-requests review of that portion of the ALJ's order that upheld SAIF's denial of his aggravation claim for a right wrist condition. Claimant also requests that the ALJ's attorney fee award be increased. On review, the issues are aggravation, attorney fees and remand.

We adopt and affirm the ALJ's order with the following supplementation regarding the attorney fee/remand issue.

The ALJ awarded claimant's attorney an assessed fee of $4,000 pursuant to ORS 656.386(1) for services provided in obtaining reversal of SAIF's denials of various right and left upper extremity conditions. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in determining the amount of the attorney fee.[1] SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award. On the other hand, claimant contends that the ALJ's attorney fee award should be increased to $8,000.[2] For the following reasons, we find that the ALJ's attorney fee award was reasonable.

We considered arguments similar to those SAIF now makes 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 Supreme Court's entire decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that, as presented here, the ALJ need not make findings for each rule-based factor.

Here, however, the ALJ simply ordered SAIF to pay "a reasonable attorney fee pursuant to ORS 656.386(1) in the amount of $4,000." Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4) on which he relied, we agree with SAIF that the ALJ did not provide reasoning sufficient for review. *See Carol E. Brown*, 51 Van Natta 58 (1999). 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.

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[1] SAIF does not contend "at this point" that the ALJ's attorney fee award was excessive.

[2] Claimant argues that SAIF's objections to his request for an increase in attorney fees should not be considered because SAIF did not timely respond to his request for a specific fee under OAR 438-015-0029. We disagree. Claimant clearly cross-requested review of the attorney fee issue. Under these circumstances, SAIF was entitled to respond to claimant's arguments for a fee increase.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Claimant has submitted a statement of services indicating that 31.9 hours were devoted to the case. The issues were compensability of claimant's right and left upper extremity conditions, premature claim closure, and aggravation. Claimant did not prevail with respect to premature claim closure and aggravation. The hearing lasted 1 hour and 20 minutes and generated 30 pages of transcript. Claimant testified on his own behalf and presented the testimony of one other witness. SAIF presented no witnesses. The record contains 69 exhibits and claimant's attorney obtained several medical reports. There was one deposition, generating 29 pages of transcript.

Based on compensability disputes generally litigated before this forum, we find the issues at hearing were of slightly above average complexity regarding the legal, medical and factual issues involved. Because several of his left and right upper extremity conditions have been found compensable, claimant is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. However, as previously noted, claimant did not prevail on the premature claim closure and aggravation issues. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and counsel's statement of services), the complexity of the issues, the value of the interest involved, the benefits secured, the nature of the proceedings (including a deposition), and the risk that counsel may go uncompensated.[3]

ORDER

The ALJ's order dated September 24, 1998 is affirmed.

[3] 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, *rev den* 302 Or 35 (1986).

February 25, 1999 Cite as 51 Van Natta 323 (1999)

In the Matter of the Compensation of
CORINNE L. BIRRER, Claimant
WCB Case Nos. 98-01138, 98-01097 & 98-01095
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Sheridan & Bronstein, Defense Attorneys

Claimant requests reconsideration of our January 28, 1999 order that upheld the self-insured employer's denials of her current left wrist condition. Claimant contends that we failed to adequately consider *Roller v. Weyerhaeuser Co.*, 67 Or App 583, *mod* 68 Or App 743, *rev den* 297 Or 124 (1984), and she also argues that the denials did not raise the issue that a separate unrelated condition was being denied.

In order to further consider claimant's request, we withdraw our prior 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 shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIETTA Z. SMITH, Claimant
WCB Case Nos. 98-04425, 97-06269 & 96-11437
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Alice M Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside SAIF's November 26, 1996 denial of a left knee degenerative condition; (2) set aside SAIF's July 11, 1997 denial of claimant's occupational disease (OD) claim for her left knee; and (3) awarded a $2,900 assessed attorney fee. SAIF also moves for remand to the ALJ. Claimant cross-requests review of those portions of the ALJ's order that upheld SAIF's November 26, 1996 and April 30, 1998 denials of claimant's OD claims for her right knee. On review, the issues are claims processing, compensability, remand and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

Claims Processing/Premature Denial

We adopt and affirm that portion of the ALJ's order that upheld SAIF's November 26, 1996 denial of claimant's right knee OD claim.

Compensability

Left Knee OD. We adopt and affirm that portion of the ALJ's order that set aside SAIF's November 26, 1996 and July 11, 1997 denials of claimant's left knee OD claims. Consequently, claimant's attorney is entitled to an assessed fee for prevailing over SAIF's request for review regarding these denials. 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 compensability issue is $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Right Knee OD. In upholding SAIF's April 30, 1998 denial of a right knee OD, the ALJ found that the right knee condition had not resulted in the need for treatment or disability. On review, claimant requests clarification that the ALJ's ruling will not preclude a future OD claim for the right knee condition should it require treatment or become disabling. Should the Board decline to provide the requested clarification, claimant challenges the ALJ's ruling on the merits.

We adopt and affirm the ALJ's conclusion and rationale on this issue with the following comment. We decline to address whether the ALJ's decision would preclude future litigation regarding claimant's right knee condition. The preclusive effect of the ALJ's ruling is not a ripe issue unless and until SAIF denies a claim for a right knee OD based on a future need for treatment or disability. Thus, we decline to issue what, in effect, would be an advisory opinion. *See Jerald J. Cooper*, 50 Van Natta 146 (1998) (Board declines to address whether doctrine of "issue preclusion" would bar future litigation regarding the insurer's entitlement to an offset); *Jimmie D. Jordan*, 43 Van Natta 1161 (1991) (Board declines to issue advisory opinions on matters of potential dispute). *See also Scott C. Clark*, 47 Van Natta 133 (1995) (Board declines to issue advisory opinion).

Left Knee Injury. The ALJ set aside SAIF's November 26, 1996 denial "to the extent that it denied claimant's left knee degenerative condition" and upheld that denial "in all other respects." On review, SAIF asserts that this order language effectively set aside its denial of a left knee injury, and that this ruling is improper because claimant proceeded solely on an OD theory at hearing.

The transcript of the hearing substantiates SAIF's assertion that claimant did not proceed under an injury theory. And, in her respondent's brief, claimant concedes that the denial of the left knee injury should be upheld. Accordingly, we modify the ALJ's order language to clarify that the left knee injury denial is upheld, and only the left knee OD denial is set aside.

Attorney Fees

The ALJ awarded claimant's attorney a $2,900 assessed attorney fee for prevailing over SAIF's denial of her left knee condition. The ALJ's order contained the following rationale in support of the attorney fee award:

> "In determining a reasonable fee amount, I have considered the factors set forth in OAR 438-015-0010(4), particularly the average amount of time devoted to the left knee claim, the average complexity of the compensability issue, the slightly above-average value of establishing an initial claim for a degenerative knee condition, and the substantial risk that claimant's attorney's services might have gone uncompensated[.]"

Claimant's attorney is entitled to a reasonable assessed fee under ORS 656.386(1) for services provided at hearing in prevailing over SAIF's denial of claimant's left knee OD. In awarding an assessed fee under this provision, an ALJ "shall consider" the eight factors recited in OAR 438-015-0010(4).[1] Here, neither party submitted any argument to the ALJ as to how these factors should be weighed in determining a reasonable fee. And claimant's attorney did not submit a statement of services or make any specific attorney fee request regarding the services provided.

On review, SAIF argues that the $2,900 fee award is excessive, and it makes specific arguments regarding a number of the factors recited in OAR 438-015-0010(4). SAIF moves to remand this case to the ALJ for further development of the record and findings of fact regarding the ALJ's attorney fee award. SAIF asserts that the record does not provide a sufficient basis for the Board's review of the ALJ's fee award, and that the ALJ's order is insufficient because he did not make findings of fact regarding each of the eight factors in the rule and demonstrate how these findings should be weighed in determining a reasonable attorney fee. SAIF relies on *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).

We first consider SAIF's procedural challenge and request for remand. 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). We found that the *McCarthy* 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. We further reasoned that this rationale applied to OAR 438-015-0010(4) because the statute considered by the Court in *McCarthy* included the same requirement that the reviewing body "shall consider" certain enumerated factors. Thus, 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 request, 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. *Accord Russell L. Martin*, 50 Van Natta 313 (1998) (where the claimant did not make a specific fee request and neither party submitted a specific argument regarding the rule-based factors, the ALJ provided a sufficient rationale by stating that the factors recited in OAR 438-015-0010(4) were considered in determining the fee).[2]

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[1] OAR 438-015-0010(4) lists the following factors to be considered in determining a reasonable fee: the time devoted to the case; the complexity of the issue(s) involved; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured for the represented party; the risk in a particular case that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses.

[2] We found the *Martin* case distinguishable from *Schoch* because the claimant in *Martin* did not make a specific fee request, and neither party submitted a specific argument regarding the rule-based factors.

Here, as in *McCarthy*, *Underwood* and *Martin*, claimant's attorney did not submit a specific attorney fee request at hearing, and neither party submitted any argument to the ALJ as to how the rule-based factors should be weighed in determining a reasonable fee. Thus, the ALJ satisfied OAR 438-015-0010(4) by citing that rule and briefly discussing the rule-based factors he particularly considered in determining the amount of the fee. To the extent any further rationale is required, we note that remand is not warranted because the record is sufficiently developed to review the ALJ's attorney fee award, and we have the authority to modify or supplement the ALJ's findings and conclusions. ORS 656.295(5) and (6); *Underwood*, 50 Van Natta at 2332.[3]

We turn to SAIF's substantive challenge to the $2,900 fee award. SAIF specifically challenges the ALJ's findings regarding the time devoted to the case, the complexity of the issue, the value of the interest, and the risk that claimant's attorney might go uncompensated. We begin our analysis with the time devoted to the case as represented by the record.[4] Claimant retained his attorney eleven weeks prior to hearing. The documentary record includes 30 exhibits submitted by SAIF. Claimant's attorney solicited and submitted an additional dispositive concurrence letter from Dr. Becker. The hearing lasted approximately two hours and included testimony from claimant and two other witnesses. Based on compensability disputes generally litigated before this forum, we find that this case presented factual, medical and legal issues of average complexity. We further find that the interest involved and benefit secured is of average significance. While this case involved an initial claim for a left knee OD, that condition has not resulted in surgery or extended time loss. Both attorneys are experienced litigators in the field of workers' compensation law. Finally, considering the conflicting medical opinions and the standard of proof, there was a risk that claimant's attorney might go uncompensated.

In summary, after particularly considering the time devoted to the issue (the left knee OD claim), the complexity of the compensability issue, the value of the interest involved, the benefit secured, the skill of counsel, and the risk that claimant's counsel might go uncompensated, we find that the ALJ's $2,900 fee award is reasonable and should be affirmed.

Finally, we note that claimant is not entitled to an assessed fee for his attorney's services on review regarding the assessed fee issue. *See Dotson v. Bohemia Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's September 3, 1998 order is affirmed in part and modified in part. The ALJ's order is modified to set aside SAIF's November 26, 1996 denial only to the extent it denied claimant's left knee occupational disease, and to uphold that denial to the extent it denied claimant's left knee injury. The remainder of the ALJ's order is affirmed. For services on review regarding SAIF's denial of claimant's left knee occupational disease, claimant's counsel is awarded $1,200, payable by SAIF.

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[3] Pursuant to ORS 656.295(5), we may remand a case to the ALJ if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *Bailey v. SAIF*, 296 Or 41, 45 n 3 (1983). Pursuant to ORS 656.295(6), the Board may affirm, reverse, modify or supplement the order of the ALJ and make such disposition of the case as it determines to be appropriate.

[4] Claimant's attorney has not submitted a statement of services rendered at hearing.

In the Matter of the Compensation of
MELODY A. ANDERSON, Claimant
WCB Case No. 98-03578
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that affirmed an Order on Reconsideration awarding 9 percent (28.8 degrees) unscheduled permanent disability for a back condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for thoracic strain, lumbar strain, and disc herniation at L3-4. A Notice of Closure awarded 9 percent unscheduled permanent disability. After claimant underwent a medical arbiter examination, an Order on Reconsideration found that claimant did not prove that any impairment was due to the accepted conditions and affirmed the Notice of Closure.

In affirming the Order on Reconsideration, the ALJ also found that the more persuasive medical evidence did not show impairment due to the accepted conditions. Claimant challenges this conclusion, asserting that, based on the medical arbiter's report, she is entitled to 50 percent unscheduled permanent disability.[1]

In November 1997, examining orthopedic surgeon, Dr. Jones, diagnosed a "thoracic lumbar strain by history" as well as "continuing low back and leg pain of unclear etiology" and "functional overlay." (Ex. 62-3). In particular, Dr. Jones reported that "impairment measurements are invalid for rating impairment due to lack of effort, mismatch between leg raising tests, and pain behavior in the room today." (*Id.*) Dr. Jones concluded that it was "impossible to determine reduced range-of-motion due to 'post pregnancy condition' [because claimant gave birth three months prior to the examination] and industrial injury. My feeling is that [claimant] has no measurable impairment." (*Id.* at 5).

Claimant's treating neurosurgeon, Dr. Bergquist, concurred with the report. (Ex. 64). On December 31, 1997, claimant saw Dr. Bergquist, complaining that she had "developed pain" in her low back "approximately three or four weeks ago." (Ex. 65). Dr. Bergquist first stated that it was "usually impossible in most people to make a specific diagnosis as to the cause of back pain." Dr. Bergquist further noted that claimant "does not have a recurrence of the problem for which I saw her, i.e., a disc herniation and a pinched nerve in the low back" and the "symptoms are compatible with waxing and waning of symptoms due to a lumbar strain." (*Id.*)

In March 1998, Dr. Morris, medical arbiter, examined claimant. During the examination, Dr. Morris found "some mild right paraspinal tenderness in the thoracic region" and indicated that claimant attributed such pain "to a more recent on-the-job injury that took place on 12-7-97." (Ex. 72-3). According to Dr. Morris, claimant "demonstrates very limited range of motion of both the thoracic and lumbar spines" and that such limitations were "due in total to the accepted condition." (*Id.*) Furthermore, Dr. Morris thought that claimant had "a significant loss of the ability to repetitively use the lumbar and thoracic regions due to the chronicity of her spinal pain, which has arisen out of the accepted conditions." (*Id.*) Finally, Dr. Morris reported his "diagnostic impression" of "residual lumbar radiculopathy, L3-4, due to herniated lumbar disc and also residuals of thoracic spinal and lumbar spinal strain. It is my opinion that there is minimal functional overlay." (*Id.* at 4).

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[1] No contention has been made that claimant's 9 percent unscheduled permanent disability award, as granted by the Notice of Closure and affirmed by the Order on Reconsideration, should be reversed.

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. *See Orfan A. Babury*, 48 Van Natta 1687 (1996). This "preponderance of the evidence" consists of findings from 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). Thus, we do not automatically defer to the medical arbiter's opinion in evaluating a worker's permanent impairment but rely on the most thorough, complete, and well-reasoned evaluation of the claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, we find that the medical arbiter did not provide the more persuasive opinion. Although noting that claimant attributed some tenderness to a "recent" work injury and that there was "minimal functional overlay," Dr. Morris did not explain why all of claimant's impairment was due to the accepted conditions. This absence of explanation becomes more significant in light of Dr. Jones' report finding functional overlay and that claimant had no measurable impairment. Because Dr. Bergquist, who performed claimant's surgery and treated her over a period of time, concurred with Dr. Jones' report, we consider Dr. Jones' opinion to be reliable and persuasive.

In short, based on the inadequacies of Dr. Morris' opinion and the persuasive of Dr. Jones' opinion and Dr. Morris' concurrence, we find that the "preponderance of evidence" fails to show that any impairment is due to the accepted conditions. Consequently, we affirm the Order on Reconsideration. Finally, having found that claimant failed to establish impairment, we need not address social and vocational factors. OAR 436-035-0270(2).

ORDER

The ALJ's order dated November 4, 1998 is affirmed.

In the Matter of the Compensation of
SAMUEL V. BILTON, Claimant
WCB Case No. 98-05678
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its denial of claimant's occupational disease claim for a left hand tenosynovitis condition; (2) assessed a penalty for the insurer's allegedly late denial; and (3) assessed an attorney fee for the insurer's alleged discovery violation. On review, the issues are compensability, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's left hand tenosynovitis condition compensable, based on the opinion of Dr. Meeker, treating physician, noting that Dr. Meeker related claimant's condition to the repetitive grinding work claimant performed for the employer. The ALJ reasoned that Dr. Meeker's opinion was more persuasive than Dr. Button's opinion to the contrary, for two reasons. First, Dr. Meeker saw claimant closer in time to the onset of the condition, while Dr. Button did not examine claimant until after a successful course of physical therapy. The ALJ also discounted Dr. Button's opinion based on its lack of objectivity and the doctor's apparent suspicions about the validity of the tenosynovitis diagnosis in particular and the claim generally.[1]

[1] Dr. Button questioned claimant's motivations for filing the claim, based on a belief that claimant was fired after a work place altercation. Claimant explained that he quit the job after a supervisor asked him to produce a death certificate to prove that he attended a funeral while off work.

We agree with the ALJ that Dr. Button's opinion is not particularly persuasive, as explained in the Opinion and Order. But that does not help claimant's cause because we cannot say that Dr. Meeker's opinion is persuasive either.

Dr. Meeker concurred -- "in every particular" -- with Dr. Button's opinion questioning the claim. (Ex. 13). Then Dr. Meeker opined that claimant's tenosynovitis condition "is a result of constant repetitive movements of the hand" holding a grinder at work. (Ex. 15). Nothing in the record explains the inconsistencies between Dr. Meeker's agreement with Dr. Button and his later opinion supporting the claim. Because Dr. Meeker apparently changed his opinion without explanation, we cannot say that his opinion is well-reasoned or persuasive in part or as a whole. *See Moe v. Ceiling Systems*, 44 Or App 429 (1980); *Yann You*, 49 Van Natta 602 (1997), *aff'd mem* 152 Or App 248 (1998) (Doctor's opinion "as a whole" unpersuasive due to unexplained variations); *Michael A. Bracken*, 45 Van Natta 2126, 2127 (1993) (When a doctor finds a condition work-related without explaining away previously expressed doubts, the ultimate conclusion is not persuasive).

Under these circumstances, we conclude that this medically complex claim must fail for lack of persuasive supporting medical evidence. *See Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986). Accordingly, we reverse the ALJ's order, noting that claimant is not entitled to penalties or attorney fees because the underlying claim is not compensable. *See James P. Mishler*, 48 Van Natta 2400, 2402 (1996) (No unreasonable resistance to the payment of compensation where underlying claim not compensable).

ORDER

The ALJ's order dated November 6, 1998 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's penalty and attorney fee assessments are reversed.

In the Matter of the Compensation of
GEORGE B. CALDER, Claimant
WCB Case No. 95-12587
ORDER ON REMAND
Welch, Bruun & Green, Claimant Attorneys
Michael D. Whitty/Julene M Quinn (Saif), Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Calder*, 157 Or App 224 (1998). The court has reversed our order that affirmed an Administrative Law Judge's (ALJ's) order affirming an Order on Reconsideration that awarded 13 percent (24.96 degrees) scheduled permanent disability for loss of use or function of the right arm. Concluding that the medical evidence did not support our previous finding that claimant experienced a loss of arm strength due to his compensable injury, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of his finding that the "coracobrachialis" ligament was preserved during Dr. Vigeland's January 11, 1995 surgery. Instead, Dr. Vigeland's operative report refers to the "coracoacromial" ligament as having been preserved. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

In November 1993, claimant injured his right shoulder at work when he slipped and fell on ice. A rotator cuff tear was later identified, for which surgery was performed. The SAIF Corporation 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 that 100 percent of claimant's loss of strength resulted from loss of muscle or disruption of the musculotendinous unit in the right rotator cuff. In his operative report, Dr. Vigeland noted that the "coracoacromial" ligament was preserved during surgery.

SAIF closed the claim with an award of 35 percent unscheduled permanent disability for the right shoulder. Claimant requested reconsideration, disagreeing with the medical impairment findings and requesting an award of scheduled permanent disability, along with an increase in unscheduled permanent disability.

A medical arbiter, Dr. Scheinberg, examined claimant and reported that motor strength in the shoulder flexors was 3/5 on the right. Following receipt of Dr. Scheinberg's report, the Appellate Unit issued an Order on Reconsideration, reducing claimant's unscheduled award to 31 percent, but awarding scheduled permanent disability for a 13 percent loss of strength in the right arm based on Dr. Scheinberg's report of motor strength in the right shoulder flexor muscles, including the "coracobrachialis."

SAIF requested a hearing, seeking a reduction in scheduled permanent disability. SAIF agreed that, if scheduled permanent disability was reduced, claimant's unscheduled award would be increased to 35 percent.

The ALJ accepted Dr. Scheinberg's opinion that claimant had suffered loss of strength in the right shoulder flexors. The ALJ determined, by reference to a medical dictionary, that claimant's "coracobrachialis" muscle, which he believed had been mentioned in Dr. Vigeland's operative report as having been "preserved" during surgery, was involved in shoulder flexion. Because the "coracobrachialis" was located in the upper arm, the ALJ then found that claimant had suffered loss of strength in the right arm and affirmed the reconsideration order. In addition, the ALJ awarded a $2,000 attorney fee pursuant to ORS 656.382(2) for claimant's counsel's services in defending against SAIF's attempt to reduce claimant's scheduled permanent disability. SAIF requested Board review.

We adopted and affirmed the ALJ's order and awarded a $1,000 attorney fee pursuant to ORS 656.382. SAIF sought review before the court, raising the sole issue of scheduled permanent disability.

The court reversed. *SAIF v. Calder*, 157 Or App at 224. Citing *Barrett v. Coast Range Plywood*, 294 Or 641, 643 (1983), and *Bend Millwork v. Dept. of Revenue*, 285 Or 577 (1979), the court observed that it was appropriate for the Board to refer to the medical dictionary for the purpose of identifying the "coracobrachial" ligament because the dictionary definition was "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *See* OEC 201(b)(2); ORS 183.450(4). Nonetheless, noting that Dr. Vigeland's operative report did not indicate that the ligament had been affected by claimant's injury/surgery nor that Dr. Scheinberg's report had made reference to a loss of arm strength, the court concluded that our opinion went beyond the dictionary definition of "coracobrachial" ligament and also went beyond the reasonable inferences that could be drawn from the medical evidence. Determining that the medical evidence did not support our finding that claimant experienced a loss of arm strength, the court remanded for reconsideration.

In accordance with the court's instructions, we now proceed with our reconsideration of the scheduled permanent disability issue. To be entitled to permanent disability compensation for his right arm, claimant must establish the presence of permanent impairment that is due to his compensable injury. ORS 656.214(2); *Fred E. Ferry*, 48 Van Natta 2429, 2430 (1996).

As previously noted, in our prior order, we adopted and affirmed the ALJ's finding that claimant's compensable injury had caused permanent impairment in his right arm. In light of the court's opinion, it is apparent that the court rejected the ALJ's and our interpretation of the medical evidence. Based on the court's holding, it necessarily follows that the medical evidence does not establish that the compensable injury has resulted in permanent impairment in claimant's right arm.[1]

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[1] It is apparent from both the ALJ's order and the court's opinion that both mistakenly interpreted Dr. Vigeland's operative report as having referred to the "coracobrachialis" ligament. As previously noted, Dr. Vigeland's report actually referred to the "coracoacromial" ligament. (Ex. 5). The error, however, is not significant since Dr. Vigeland's operative report did not indicate that the ligament had been affected by claimant's injury/surgery, nor did Dr. Scheinberg's arbiter's report refer to a loss of arm strength. Moreover, Dr. Vigeland's closing report refers to loss of strength as being in the rotator cuff of the right shoulder. (Exs. 7, 8). Based on our *de novo* review of the record, we conclude that medical evidence does not establish the presence of permanent impairment in the right arm. *See Kim S. Anderson*, 48 Van Natta 1876 (1996) (claimant not entitled to scheduled permanent disability for alleged arm disability where arbiter only identified restricted use of the shoulders).

Accordingly, on remand and reconsideration of our June 12, 1997 order, the ALJ's order dated January 17,1997 is modified in part and reversed in part. In lieu of the ALJ's order, that portion of the Order on Reconsideration that awarded 13 percent scheduled permanent disability for loss of use or function of the right arm is reversed. In addition to the 31 percent (99.2 degrees) unscheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability for a total award to date of 35 percent (112 degrees). Claimant's attorney is awarded 25 percent of the 4 percent increase created by this order, not to exceed $2,800, payable directly to claimant's counsel. The ALJ's insurer-paid attorney fee award under ORS 656.382(2) is reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
STACY FRIERSON, Claimant
WCB Case No. 98-03225
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock, and Moller.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that affirmed an Order on Reconsideration that awarded 9 percent (28.8 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated September 4, 1998 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

Board Member Moller dissenting.

Because I disagree with the majority's reliance on the impairment findings reported by the medical arbiter, I respectfully dissent from their conclusion that claimant has established her entitlement to a permanent disability award. My decision is based on the following reasoning.

Under *former* OAR 436-035-0007(27) (current OAR 436-035-0007(28)), if validity criterion are not met but the examining physician determined the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid.

Here, the medical arbiter determined that two of claimant's range of motion findings did not fall within AMA validity criterion. Moreover, the arbiter reported that claimant's findings were "fraught with significant inconsistencies."

Under such circumstances, the medical arbiter was required to "provide a written rationale, based on sound medical principles, explaining why the findings are valid." *See former* OAR 436-035-0007(27). Rather than providing this requisite written explanation, the arbiter conclusorily stated that

the findings were "a reasonable description of the claimant's current level of function." In light of the arbiter's previous reference to "significant inconsistencies" and the documented range of motion findings that exceeded the validity criterion standards, I do not consider the arbiter's unexplained statement that the findings provide a "reasonable description of the claimant's current level of function" sufficient to constitute a "written rationale, *based on sound medical principles*, explaining why the findings are valid."

In conclusion, lacking an adequate explanation, the arbiter's findings cannot be considered in evaluating the extent of claimant's permanent impairment. Because claimant's attending physician found neither objective limitations nor neurological defects (and did not report permanent impairment), I submit that the admissible medical evidence does not support claimant's request for a permanent disability award. Consequently, I respectfully dissent from the majority's decision to affirm the ALJ's order.

In the Matter of the Compensation of
RITA HARRIS, Claimant
WCB Case No. 98-04574
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the SAIF Corporation's partial denial of her right shoulder calcific tendinitis condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the second full paragraph on page 3, we change the date in the fourth sentence to "April 8, 1997."

The ALJ found that a March 9, 1998 Opinion and Order from another ALJ had determined that claimant had calcific tendinitis in her right shoulder that preexisted her May 1996 work injury. Claimant argues that the prior litigation was not determinative and her right shoulder calcific tendinitis was not preexisting.

Even if we assume, without deciding, that the previous litigation had no effect on the "preexisting condition" issue, we nevertheless conclude that the medical evidence establishes that claimant's right shoulder calcific tendinitis preexisted her May 1996 work injury.

Claimant relies on the opinion of Dr. Wuest to support her argument that the calcific tendinitis condition did not preexist her work injury. Dr. Wuest performed surgery on claimant's right shoulder on July 10, 1998. (Ex. 39). When he was asked by SAIF whether claimant had calcific deposits and calcific tendinitis *before* her May 1996 injury, Dr. Wuest responded that he did not know whether or not they were preexisting. (Ex. 38).

In contrast, Dr. White reported that claimant had a "great deal of underlying right shoulder pathology as attested to by the presence of extensive calcification in tendons and joint structures about the shoulders, especially the right." (Ex. 10-7). He concluded that the major contributing cause of claimant's symptoms and disability was the preexisting "extensive" calcific tendinitis in her right shoulder. (Ex. 10-8). Similarly, Dr. Bald believed that claimant's right shoulder calcific tendinitis preexisted the May 1996 injury. (Exs. 11, 21). He explained that claimant had "clearly preexisting extensive calcific tendinitis of both shoulders[.]" (Ex. 21-3).

Based on the reports from Drs. Bald and White, we conclude that claimant had calcific tendinitis in her right shoulder that preexisted her May 1996 work injury. We agree with the ALJ's reasoning and conclusion that claimant did not sustain her burden of proving compensability of her right shoulder calcific tendinitis condition.

ORDER

The ALJ's order dated October 9, 1998 is affirmed.

February 26, 1999 Cite as 51 Van Natta 333 (1999)

In the Matter of the Compensation of
DALE A. KIBBLE, Claimant
WCB Case No. 97-10233
ORDER ON REVIEW
Daniel J. DeNorch, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded an assessed attorney fee of $1,750. Claimant cross-requests review of the same issue, contending that he is entitled to a greater attorney fee award. 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

The ALJ found that claimant proved compensability. The ALJ also found that, "[b]ased on all of the factors in OAR 438-015-0010(4)[1] as they are determinable on this record, including, but not limited to, the nature of the case and the value of the interest involved, claimant's attorney is entitled to a $1,750 assessed attorney fee."

SAIF requests review of only that portion of the order awarding an attorney fee, arguing that, because "the factors were mentioned only in a conclusory manner and certainly findings were not made as to each of the eight factors," the ALJ's order is "woefully inadequate to justify any award of an attorney fee." SAIF also moves to "remand this case to the ALJ with instructions to take evidence and to properly apply OAR 438-015-0010(4)." Claimant opposes SAIF's motion for remand, arguing that the Board may "make its own assessment of an attorney fee." Claimant also contends that the ALJ's attorney fee is unreasonable and that he should be awarded a fee of $5,500.

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. Instead, 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. *See McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998); *Turnbow v. K.E. Enterprises, Inc.*, 155 Or App 59 (1998) (citing *McCarthy* for its holding that the absence of explanatory findings to support an award or a denial of attorney fees is not a ground for reversal and a court need only address the objections under the statute that are material to its decision).

Here, because the ALJ indicated that she applied the rule-based factors in determining the attorney fee, we find the ALJ's order sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.[2] In addition to the ALJ's order, we provide the following reasoning.

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[1] In determining a reasonable attorney fee under OAR 438-015-0010(4), we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

[2] In any event, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6) and because we consider the record to be sufficiently developed to make findings and conclusions, remand would not be necessary. *See* ORS 656.295(5); *Daryl L. Underwood*, 50 Van Natta 2330, 2332 (1998).

The issues at hearing were jurisdiction and compensability of claimant's cervicothoracic paravertebral myofibrosis and grade II cervical sprain with motion segment instability condition. The ALJ upheld those portions of SAIF's denial concerning myofibrosis and motion segment instability. The ALJ set aside SAIF's denial of "grade II cervical sprain."

Although claimant's attorney did not provide a written statement of services at hearing, on review he estimates that he expended 30 hours on the case. The hearing lasted approximately four hours. Claimant's treating chiropractor testified on claimant's behalf and an examining chiropractor testified on SAIF's behalf. The record contains 68 exhibits, including one deposition.

Because only the "grade II cervical sprain" was found compensable, claimant's attorney is entitled to a fee for services devoted to this condition. Based on compensability disputes generally litigated before this forum, we find the compensability issue for the "grade II cervical sprain" was of average complexity regarding the legal and factual issues involved. Because claimant's cervical sprain condition has been found compensable, he is entitled to workers' compensation benefits; we find that the value of the interest involved and the benefit secured for claimant are average. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, based on competing medical opinions concerning causation, there was a risk that claimant's counsel's efforts might have gone 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 issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated. Claimant's counsel is not entitled to an attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated October 19, 1998 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded an assessed attorney fee of $3,000 for services at hearing. The remainder of the order is affirmed.

In the Matter of the Compensation of
FRANKIE LAVERDURE, Claimant
WCB Case No. 98-05210
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
VavRosky, MacColl, Olson, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that affirmed an Order on Reconsideration that reduced her award of scheduled permanent disability for loss of use or function of her right foot from 23 percent (31.05 degrees), as granted by a Notice of Closure, to 7 percent (9.45 degrees). On review, the issue is scheduled permanent disability.

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

Claimant's attending physician, Dr. Satterfield, declared claimant medically stationary with regard to her accepted right foot injury on December 22, 1997. Dr. Satterfield did not perform a closing examination, noting that the impairment rating would be "done by someone else." (Ex. 25). An employer-arranged "IME" panel, consisting of examining physicians Drs. Woodward and Platt, made impairment findings on December 23, 1997. (Ex. 26). The employer used the panel's findings to rate impairment in a January 14, 1998 Notice of Closure, even though the record does not contain a concurrence with those findings by Dr. Satterfield. (Ex. 27). The Notice of Closure awarded 23 percent scheduled permanent disability.

Claimant requested reconsideration, but did not disagree with the impairment findings used to rate disability. The Department, however, scheduled a medical arbiter's examination because the attending physician had not concurred with the IME panel's findings. Based on the arbiter's report, the reconsideration order reduced claimant's scheduled permanent disability to 7 percent. Claimant requested a hearing.

The ALJ determined that the IME findings could not be used to rate permanent impairment because the attending physician had not concurred with the findings. On review, claimant contends that, assuming the ALJ was correct, the Order on Reconsideration should have set aside the Notice of Closure because the claim was closed without benefit of a closing examination. We disagree.

We held in *Estella M. Rogan*, 50 Van Natta 205 (1998), that the Department is not authorized to set aside a carrier's closure notice as premature on the basis that the insurer did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). There, the carrier closed the claimant's claim by Notice of Closure based on the attending physician's declaration that the claimant's condition was medically stationary without permanent residuals. On reconsideration, the Department rescinded the closure notice, reasoning that, because no closing examination had been performed, the carrier did not obtain adequate closing information. The ALJ affirmed the Order on Reconsideration. On review, we reversed, finding that neither the statutes nor the rules require a closing examination report as a prerequisite for issuance of a carrier's closure notice.

In reaching this conclusion, we explained that ORS 656.268(4)(a) sets forth only two prerequisites for a carrier's claim closure. The claim may be closed when: (1) the worker's condition has become medically stationary and the worker has returned or been released to work; or (2) the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. We reasoned that, because a closing examination report is not a condition precedent to issuance of a closure notice, the absence of such a report was not grounds for setting aside a closure notice as "premature." We also noted that, to the extent OAR 436-030-0020(4)(a) could be read to require a closing examination prior to issuance of a valid closure notice, the rule exceeded the terms of ORS 656.268 and should be given no effect. 50 Van Natta at 205.

Here, claimant's attending physician, Dr. Satterfield, declared her accepted condition medically stationary and released her for modified work prior to the employer's issuance of the Notice of Closure. (Ex. 25). Thus, the statutory conditions precedent to issuance of the closure notice were satisfied in this case. *See* ORS 656.268(4)(a). Because the employer's Notice of Closure was authorized by statute, it is valid.[1]

Claimant next argues that the report of the examining physicians should be used to rate permanent disability. Claimant asserts that Dr. Satterfield "delegated" the rating of impairment to the examining physicians and that this is permissible because there does not need to be an explicit concurrence by an attending physician with the impairment findings of an "IME." For the following reasons, we are not persuaded by claimant's argument.

With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. ORS 656.245(2)(b)(B); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994), *aff'd Liberty NW Insurance Corp. v. Koitzsch*, 155 Or 494 (1998). However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. *See* OAR 436-035-0007(12); *Roseburg Forest Products v. Owen*, 127 Or App 442 (1994).

In this case, Dr. Satterfield stated that "actual rating is to be done by someone else." While the examining physicians did provide impairment findings, Dr. Satterfield never "ratified" those findings either implicitly or explicitly. She made no comment on them whatsoever as far as this record discloses. To the extent that the administrative rules contemplate "delegation" of impairment ratings to consulting or examining physicians, there must still be ratification of those impairment findings by the attending physician. Because there was no ratification or concurrence in this case, the ALJ correctly determined that the impairment findings of the examining physicians may not be used to rate permanent disability.

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[1] Though not a basis for rescinding claim closure, a carrier's failure to comply with the Department's regulatory requirements may be the basis for assessment of civil penalties by the Director pursuant to ORS 656.745(2). *See* OAR 436-060-0200(2).

Finally, claimant contends that the employer is "estopped" from arguing that the attending physician did not concur with the examining physicians' report because it closed the claim based on the impairment findings contained in the IME.

It appears that claimant raised the estoppel argument for the first time in her reply brief. Thus, we are not inclined to address the issue 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).

Moreover, even assuming the issue was properly raised, the doctrine of equitable estoppel only protects those who materially change their position in reliance on another's acts or representations. *Meier & Frank Co. v. Smith-Sanders*, 115 Or App 159, 163 (1992). Here, claimant has made no showing that she materially changed her position in reliance on the employer's actions in closing the claim. Thus, we did not find claimant's estoppel argument persuasive.

ORDER

The ALJ's order dated October 16, 1998 is affirmed.

February 26, 1999 Cite as 51 Van Natta 336 (1999)

In the Matter of the Compensation of
DENNIS D. MITCHELL, Claimant
WCB Case No. 98-01067
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) affirmed an Order on Reconsideration award of 5 percent (16 degrees) unscheduled permanent disability for a back injury; and (2) awarded an assessed attorney fee of $1,800. SAIF also moves for remand. On review, the issues are extent of unscheduled permanent disability, remand and attorney fees.

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

Attorney Fees

After determining that claimant's unscheduled permanent disability award should not be reduced, the ALJ awarded an assessed attorney fee under ORS 656.382(2). The ALJ considered the factors set forth in OAR 438-015-0010(4) and found that below-average time had been devoted to the permanent disability issue, the complexity of the issue was below average and the value of the interest involved and benefit obtained were below-average. The ALJ concluded that a reasonable fee amount was $1,800.

On review, SAIF contends that, under *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), the ALJ's order is insufficient with regard to the attorney fee award. SAIF contends that the ALJ was required to make specific findings of fact for each of the factors in OAR 438-015-0010(4)[1] and, because the order failed to do so, asks the Board to vacate and remand.

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[1] In determining a reasonable attorney fee, the rule requires the ALJ to consider the following factors: (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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to merely describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See McCarthy*, 327 Or at 188; *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, because the ALJ indicated that he had considered the factors in OAR 438-015-0010(4) in assessing the fee, we find the order, as well as the record, sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.

In addition to the ALJ's discussion, we note the following. The hearing lasted nearly one and one-half hours. The record consisted of 35 exhibits, 8 of which were submitted by claimant's attorney. We agree with the ALJ that the permanent disability issue was of below-average complexity, as were the value of the interest involved and benefit obtained. The parties' attorneys presented their positions in a thorough manner. No frivolous issues or defenses were presented. In light of the possible interpretations of the medical arbiter panel's report, there was a risk that claimant's attorney's efforts might have gone uncompensated. After considering the factors in OAR 438-015-0010(4), we agree with the ALJ that $1,800 is a reasonable attorney fee.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the permanent disability issue is $750, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for defending the attorney fee on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated October 23, 1998 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the SAIF Corporation.

In the Matter of the Compensation of
CLARENCE A. MOORE, Claimant
WCB Case Nos. 98-00560 & 97-06763
ORDER ON RECONSIDERATION
Scott McNutt, Sr., Claimant Attorney
James B. Northrop (Saif), Defense Attorney
William J. Blitz, Defense Attorney

On January 26, 1999, we abated our January 13, 1999 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that found Barrett Business Services (Barrett) responsible for claimant's right knee medial meniscus tear. Barrett requested reconsideration, indicating that its counsel had only recently received a copy of claimant's respondent's brief. We granted Barrett an opportunity to file a supplemental reply brief that addressed claimant's respondent's brief. Having received Barrett's supplemental reply brief, we proceed with our reconsideration.

Among other things, Barrett argues that claimant did not report the alleged February 14, 1997 injury to Barrett until July 2, 1997. Barrett contends that this is "well beyond" the 90 days as required in ORS 656.265.

We acknowledge that Barrett's August 12, 1997 letter denied the claim based, in part, on claimant's failure to report the claim within a timely manner. (Ex. 11). Nevertheless, we find no evidence that Barrett raised this issue at hearing, nor did the ALJ address this particular issue. We further note that Barrett did not previously raise this issue on review. Under these circumstances, we are not inclined to address Barrett's argument concerning ORS 656.265. *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).

In any event, even if we assume that Barrett properly raised this issue, we find that claimant's claim was timely under ORS 656.265. As we discussed in our prior order, we found that claimant's right knee symptoms began on February 14, 1997, while removing scuff marks from the floor. Because his symptoms were sudden in onset and occurred over a discrete, identifiable period of time, we concluded that the claim should be analyzed as one for an accidental injury.

ORS 656.265(1) provides, in 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 that failure to give notice as required by this section bars a claim unless the notice is given within one year after the date of the accident and the employer had knowledge of the injury or death.

Claimant signed an "801" form with Barrett regarding his right knee claim on July 2, 1997, more than 90 days after the accident. (Ex. 4). Because notice was given within one year of the accident, the claim is not barred if Barrett had knowledge of the injury. Claimant testified that he told Mr. Campbell, his employer, of his right knee problem on the day the injury occurred. (Tr. 9). He also mentioned the injury to Mr. Campbell the day after he went to the hospital, which was on March 13, 1997. (*Id.*) Mr. Campbell agreed claimant had discussed the knee injury with him in either February or March 1997. (Tr. 42). Mr. Campbell said he had no reason to doubt claimant's credibility. (Tr. 43). Based on the testimony of claimant and Mr. Campbell, we conclude that Barrett had knowledge of claimant's injury at least by March 1997 and, therefore, the claim is not barred. *See* ORS 656.265(4)(a).

After considering Barrett's remaining arguments, we have nothing further to add to our prior order. We adhere to our previous opinion that Barrett Business Services is responsible for claimant's right knee medial meniscus tear condition.

On reconsideration, as supplemented herein, we adhere to and republish our January 13, 1999 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
LEROY E. AUGUSTUS, Claimant
WCB Case No. 98-03853
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 1 percent (1.92 degrees), as awarded by an Order on Reconsideration, to 30 percent (57.6 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant was employed in janitorial services when he compensably injured his right elbow on June 12, 1997. (Ex. 1). SAIF accepted a right elbow strain. (Ex. 3). On December 3, 1997, Dr. Mandiberg declared claimant medically stationary, noting that he was performing regular work. (Ex. 2). Dr. Mandiberg reported that claimant had 1 percent impairment for the loss of 8 degrees of extension of his elbow. (*Id.*)

A December 18, 1997 Notice of Closure awarded claimant 2 percent (3.84 degrees) scheduled permanent disability for loss of use or function of the right arm. (Ex. 4). Claimant requested reconsideration. Dr. Solhberg performed a medical arbiter examination on April 1, 1998. (Ex. 5). An Order on Reconsideration issued on April 13, 1998, reducing claimant's scheduled permanent disability for loss of use or function of the right arm to 1 percent. (Ex. 6).

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought additional permanent disability awards for a chronic condition and decreased grip strength. The ALJ concluded that claimant was not entitled to a chronic condition award, but she did award additional permanent disability for claimant's decreased grip strength. The ALJ relied on anatomy texts provided by claimant to find that the median nerve and ulnar nerve were involved in grip strength, concluding that claimant was entitled to a total scheduled permanent disability award of 30 percent.

SAIF argues that the ALJ erred in giving an award for loss of grip strength in the right hand. SAIF contends that the ALJ erroneously determined that claimant's diminished grip strength was a direct medical sequelae of his compensable right elbow strain.

Claimant contends that he is entitled to prove his case by a preponderance of evidence, both direct and indirect. He relies on the Department's standard instructions to the medical arbiter regarding the loss of use or function as a result of muscle weakness. According to claimant, the Board may reasonably infer from the Department's instructions and Dr. Sohlberg's response that the loss of strength was caused by the compensable injury. We disagree.

As SAIF points out, the Department's instructions to Dr. Sohlberg were not admitted in evidence. Even if the Department's instructions are "standard," as claimant asserts, the record does not establish that those instructions were sent to Dr. Sohlberg. Thus, to the extent claimant asks us to take "administrative notice" of the Department's instructions, we decline to do so.

After reviewing the record, we agree with SAIF that there is no evidence that claimant's diminished grip strength was a direct medical sequelae of his compensable right elbow strain. ORS 656.268(16) provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

Under ORS 656.266, claimant has the burden of proving the nature and extent of any disability resulting from a compensable injury. In *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), we considered whether the claimant's unaccepted cervical and thoracic conditions were "direct medical sequela" under ORS 656.268(16) of the accepted right shoulder tendonitis condition. The ALJ had awarded permanent disability for loss of cervical range of motion. Based on the language of ORS 656.268(16), as well as

ORS 656.262(7) and ORS 656.283(7), we concluded that, in the absence of evidence that the unaccepted conditions were "direct medical sequela" of the accepted condition (as opposed to the accidental injury from which the accepted condition arose), the claimant was not entitled to permanent disability based on the unaccepted conditions. *See also Donald D. Davis*, 50 Van Natta 357, *on recon* 50 Van Natta 682 (1998) (the claimant failed to show that his epicondylitis condition was a "direct medical sequela" of the accepted left elbow contusion).

Here, SAIF accepted a right elbow strain. (Ex. 3). Based on this record, we find no medical evidence that establishes that claimant's reduced grip strength is "due to the accepted condition" or that it constituted "direct medical sequelae" to the accepted condition of a right elbow strain. Claimant's attending physician at the time of claim closure, Dr. Mandiberg, did not refer to any diminished grip strength. (Ex. 2). Rather, he found claimant's muscle strength was 5/5 on testing all major muscle groups. He felt that claimant had 1 percent impairment for the loss of 8 degrees of extension of his elbow. (*Id.*)

The only reference to a finding of reduced grip strength was in the medical arbiter's report. In his report, Dr. Sohlberg did not indicate what condition had been accepted. He estimated that claimant had 5 degrees loss of elbow extension on the right. (Ex. 5-2). He reported that claimant's muscle strength was 5/5 in elbow flexion and extension and grip strength was 70 pounds on the right and 120 on the left. (*Id.*) Dr. Sohlberg, however, did not indicate that the reduced grip strength was a "direct medical sequela" of the accepted right elbow strain or even that it was related to the accepted condition. Instead, he ambiguously wrote: "Again the only abnormalities in terms of motion and strength and sensation *is* the slight loss of elbow extension. The loss of grip strength is notable as is the subjective history of intermittent pain complaints." (Emphasis supplied). Because claimant has failed to show that the diminished grip strength was a "direct medical sequela" of the accepted elbow condition or otherwise due to the compensable injury, we conclude that he is not entitled to a permanent disability award based on that finding of impairment.[1] *See* ORS 656.268(16); *Julio C. Garcia-Caro*, 50 Van Natta at 163.

ORDER

The ALJ's order dated September 16, 1998 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

[1] In light of our conclusion, we need not address SAIF's argument that OAR 436-035-0007(18)(b), which allows the use of current anatomy texts to identify which peripheral or spinal nerve root supplies (innervates) certain muscles, is an unconstitutional delegation of legislative authority.

In the Matter of the Compensation of
ALBERT NACOSTE, Claimant
Own Motion No. 99-0002M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable facial contusion and post-concussion headaches injury. Claimant's aggravation rights expired on August 2, 1983. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant is not in the work force.

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

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] It would appear that claimant is not clear as to what his rights are under his own motion claim. The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words; it addresses issues presented to it from disputing parties. Because of that role, the Board is an impartial party. Inasmuch as claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97310

In the Matter of the Compensation of
JANICE M. DAVISON, Claimant
WCB Case No. 98-02573
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that reduced claimant's award of unscheduled permanent disability from 38 percent (121.6 degrees), as awarded by an Order on Reconsideration, to 30 percent (96 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant, a school bus driver, sustained multiple injuries when involved in a motor vehicle accident in December 1994. Dr. Goodwin performed surgery in June 1996 to treat a herniated disc at C5-6. Following surgery, claimant complained of swallowing and speech difficulties that Dr. Goodwin attributed to the surgery. In November 1997, the insurer accepted vocal cord paralysis and a condition diagnosed as "cricopheryngeal achalasia" as sequelae of the compensable injury.

The insurer closed the claim by Notice of Closure issued on November 26, 1997, awarding 17 percent unscheduled permanent disability. Claimant requested reconsideration which resulted in a medical arbiter's examination performed by Dr. Hiatt, an ENT specialist. Dr. Hiatt rated claimant's upper digestive tract impairment as class II (15 percent impairment under OAR 436-035-0420(2)); her speech impairment as class II (9 percent impairment under OAR 436-035-0385(8)); and her air passage deficit as class I (5 percent impairment under OAR 436-035-0385(6)).

Combining these values with cervical impairment of 17 percent, the Department calculated claimant's final impairment value as 38. The reconsideration order then awarded claimant 38 percent unscheduled permanent disability based on impairment alone, concluding that claimant had been released to regular work that was available, but that claimant had refused to perform for reasons unrelated to the compensable injury. (Ex. 32).

The insurer requested a hearing, seeking a reduction of claimant's permanent disability. Claimant cross-requested a hearing, seeking additional permanent disability.

At hearing, the parties did not contest the 17 percent rating for cervical impairment and agreed that the arbiter's report should be used to rate claimant's throat/upper digestive tract impairment. The ALJ agreed with Dr. Hiatt's impairment rating, with the exception of his evaluation of claimant's upper digestive tract impairment.

Instead of Dr. Hiatt's class II rating, the ALJ determined that claimant was entitled to class I (3 percent) impairment. Combining this value with the other impairment values (17, 5 and 9), the ALJ rated claimant's impairment as 30 percent. The ALJ then addressed the issue of whether claimant should receive values for non-impairment values such as age, education and adaptability. The ALJ concluded that she should not, finding that claimant had been released to regular work. *See* ORS 656.726(3)(f)(D).[1] Accordingly, basing claimant's permanent disability award entirely on impairment, the ALJ reduced claimant's unscheduled award from 38 to 30 percent.

On review, claimant contends that Dr. Hiatt's class II rating for her upper digestive tract impairment was correct. In addition, claimant asserts that she is entitled to values for age, education and adaptability because she was not released to regular work. For the following reasons, we conclude that claimant's unscheduled permanent disability award should be increased.

Upper Digestive Tract Impairment

OAR 436-035-0420(2) provides that:

"Impairment of the upper digestive tract (esophagus, stomach and duodenum, small intestine, pancreas) shall be valued according to the following classes:

"(a) Class 1 (3% Impairment)

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

"(B) Continuous treatment is not required; and

"(C) Weight can be maintained at the desirable level; or

"(D) There are no sequelae after surgical procedures.

"(b) Class 2 (15% Impairment)

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

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

"(C) Loss of weight below the "desirable weight"* does not exceed 10%.

"(c) Class 3 (35% Impairment)

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[1] Pursuant to ORS 656.726(3)(f)(D), impairment is the only factor to be considered in evaluating the worker's disability if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury."

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

"(B) Appropriate dietary restrictions and drugs do not completely control symptoms, signs, and/or nutritional state; or

"(C) There is 10-20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract.

"(d) Class 4 (63% Impairment)

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

"(B) Symptoms are not controlled by treatment; or

"(C) There is greater than a 20% loss of weight below the "desirable weight"* which is ascribable to a disorder of the upper digestive tract."

The ALJ interpreted the criteria for class II impairment as requiring dietary restrictions, drug therapy *and* weight loss. Because there was no evidence that claimant had difficulty maintaining weight, and because the ALJ determined that class I did not require difficulty with weight maintenance, the ALJ held that claimant's impairment most appropriately belonged in class I.

Claimant contends, however, that the ALJ incorrectly interpreted class II as requiring weight loss. Instead, claimant asserts that the rule merely states that weight loss, *if any*, may not exceed 10 percent before impairment becomes class III impairment. Claimant argues that the ALJ imposed a requirement that the terms of the administrative rule does not.

In *SAIF v. Hernandez*, 155 Or App 401, 406 (1998), the court rejected a similar argument and held that, in order to be entitled to Class II impairment under OAR 436-035-0420(2), a claimant must show, in part, a weight loss below the desirable weight provided in the standards that does not exceed 10 percent as of the issuance of the reconsideration order. *See also Jose L. Hernandez*, .50 Van Natta 2058 (1998) (on remand).

Moreover, as the ALJ noted, class II is stated in the conjunctive, *i.e.*, dietary restrictions *and* drug therapy must be necessary for control of symptoms, signs and/or nutritional deficiency. The evidence in this case does not establish that drug therapy is required treatment for claimant's condition. Therefore, even assuming weight loss was not required under class II, claimant's impairment would still not qualify for that classification.

Accordingly, we conclude that the ALJ properly rated claimant's upper digestive tract impairment as class I. Because there is no dispute regarding the other impairment values, we further agree that claimant's overall impairment value is 30. The question then becomes whether claimant's impairment should be based on permanent impairment alone or whether the impairment value should be modified by values for age, education and adaptability.

Return to Work Issues

At hearing, claimant contested the Department's finding that she had been released to regular work and, therefore, was entitled to permanent disability based solely on impairment. In particular, claimant objected to the Department's reliance on an unsigned affidavit of a school district employee who averred that claimant's regular job was available to her, but that she did not return to that job for reasons unrelated to the compensable injury. (Ex. 31A).

Noting that the reconsideration order had already issued when the signed and notarized affidavit was submitted (Exs. 33, 34), the ALJ held that the Department should not have relied on the unsigned affidavit because it was not a document on which a reasonably prudent person would rely. Despite that finding, the ALJ nevertheless held that claimant had been released to regular work by Dr. Goodwin. (Ex. 8-2). Thus, the ALJ concluded that ORS 656.726(3)(f)(D) barred any "enhancement" of claimant's permanent disability award.

We agree with the ALJ that claimant was released to regular work. (Exs. 8-2, 14). That does not end the inquiry, however. ORS 656.726(3)(f)(D) also requires that the regular job be available and that the worker failed or refused to return to that job. *Anna Tate*, 51 Van Natta 184 (1999). The only evidence in the reconsideration record regarding the availability of the regular job was the unsigned affidavit. The ALJ determined that the document was inadmissible because it was not properly received into the reconsideration record.

We disagree with the ALJ's decision to exclude the exhibit. The affidavit was in the reconsideration record and, as such, is admissible at hearing and will be considered on review regarding the extent of disability issue. *See* ORS 656.283(7); *Gail J. Keller*, 50 Van Natta 2144 (1998) (review an ALJ's evidentiary ruling for abuse of discretion); *Edison L. Netherton*, 50 Van Natta 771 (1998).

Our evidentiary ruling notwithstanding, the question remains as to the probative weight to be accorded that document. Because it was unsigned, we conclude that, while admissible, the affidavit has no probative weight and, therefore, does not establish that claimant's regular job was available.

As previously noted, a signed and notarized affidavit was submitted to the Department. (Exs. 33, 34). This document, however, was not submitted until after the reconsideration order had issued. Thus, unlike the unsigned affidavit, the signed affidavit was not part of the reconsideration record. Therefore, since our review is limited to the reconsideration record, the signed affidavit cannot be considered on the return to work issue. ORS 656.283(7).[2] Because of this, the record does not establish that claimant's regular job was available or that claimant refused or failed to return to that job. Claimant is, thus, entitled to consideration of non-impairment factors in the calculation of permanent disability.

Calculation of Unscheduled Permanent Disability

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).

Claimant was 60 years old at claim closure and has 12 years of education. (Ex. 13-1). Claimant is entitled to a value 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 4 based on the job providing the highest SVP number during the 5 years prior to the time of determination (Bus Driver, DOT 913.463-010). OAR 436-035-0300(3). This results in a value of 3. OAR 436-035-0300(4). Therefore, the age and education total is 4.

With respect to adaptability, based on a comparison of claimant's base functional capacity (medium), which we have determined pursuant to OAR 436-035-0310(4)(a), with claimant's maximum residual functional capacity (sedentary/light), based on the May 6, 1997 physical capacities evaluation (Ex. 18-1), claimant is entitled to an adaptability factor of 4. OAR 436-035-0310(6). Multiplying the age/education value (4) times the adaptability factor (4), the product is 16. When added to the impairment value of 30, the sum is 46. Therefore, claimant's unscheduled permanent disability is 46 percent. Accordingly, we modify the ALJ's unscheduled award.

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[2] Although the signed affidavit was part of the hearing record, claimant did object to its admission in her written closing argument. Thus, we have addressed the admissibility of the signed affidavit. *See Stanley M. Shaw* (Deceased), 50 Van Natta 1056, 1057 n.2 (1998) (distinguishing *Fister v. SAIF*, 149 Or App 214 (1997), where the court held that, because the employer did not object at hearing to the claimant's testimony that was not submitted during reconsideration, the Board should not have entertained the employer's argument, first made to the Board, that the testimony was not admissible). Claimant suggests that we may take administrative notice of the date of the receipt of the signed affidavit by review of date stamps. Even if we could do as claimant suggests, those date stamps indicate that the signed affidavit was not received by the Department until March 9, 1998, which is after the March 6, 1998 reconsideration order had issued. In any event, this is not an appropriate case for administrative notice. *See Raymond A. Baker*, 47 Van Natta 309, *on recon* 47 Van Natta 481, 482 (1995) (no administrative notice of a date stamp).

Because we have awarded 46 percent unscheduled permanent disability and the ALJ's order awarded 30 percent, our order results in increased compensation. Therefore, claimant's attorney is entitled to an "out-of-compensation" fee equal to 25 percent of the increased compensation created by this order (the 16 percent difference between the ALJ's order and this order), not to exceed $3,800. *See* ORS 656.386(2); OAR 438-015-0055(1). In the event that any of this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd Volk v. America West Airlines, 135* Or App 565 (1995).

ORDER

The ALJ's order dated July 21, 1998 is modified. In lieu of the ALJ's order, and in addition to the 38 percent (121.6 degrees) unscheduled permanent disability granted by the March 6, 1998 Order on Reconsideration, claimant is awarded 8 percent (25.6 degrees), for a total award of 46 percent (147.2 degrees) unscheduled permanent disability. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (the 16 percent unscheduled permanent disability difference between the ALJ's order and this order), not to exceed $3,800, payable directly to claimant's counsel. In the event that a portion of this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in *Jane A. Volk.*

March 2, 1999 Cite as 51 Van Natta 345 (1999)

In the Matter of the Compensation of
BRENDA FOIL, Claimant
WCB Case Nos. 98-00725 & 97-02637
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Sheridan, Bronstein & Levine, Defense Attorneys
Hoffman Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) set aside its compensability and responsibility denials of claimant's occupational disease claim for bilateral tendinitis; (2) upheld Twin City Insurance Company's *de facto* denials of compensability and responsibility for the same condition; and (3) awarded an assessed attorney fee of $4,200. In her brief, claimant challenges that portion of the ALJ's order that upheld the employer's denial of her occupational disease claim for a ganglion cyst. On review, the issues are compensability, responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the ALJ's reasoning and conclusion concerning the compensability of claimant's bilateral tendinitis condition. We supplement the ALJ's order as follows.

Compensability - Ganglion Cyst

In her brief, claimant contends that the ALJ erred by concluding that her ganglion cyst was not compensable.[1] Based on our *de novo* review, we agree with the ALJ's reasoning and conclusion that claimant has failed to sustain her burden of proving compensability of the ganglion cyst.

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[1] Although the employer argues that we should not address this issue because claimant did not cross-request review, it is well-settled that a party may contest any portion of an ALJ's order in the absence of a timely cross-appeal, provided that the other party which requested review does not withdraw its request for review. *See, e.g., Pamela G. Frank*, 50 Van Natta 219 (1998).

Attorney Fee - Hearings Level

The employer argues that the ALJ's attorney fee award of $4,200 is "astronomical and outrageous." Claimant responds that the attorney fee was reasonable and was even on the "lower end" of the fee scale when compared to similar cases. In her brief, claimant asserts that she is also entitled to an attorney fee under ORS 656.308(2)(d) for prevailing on the issue of responsibility.

We agree with claimant's assertion that she is entitled to a fee under ORS 656.308(2)(d) for services concerning the responsibility issue. Therefore, 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 regarding the bilateral tendinitis condition 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. Approximately 41 exhibits were admitted at hearing, at least three of which were generated by claimant's attorney. There were three depositions, with transcripts of 70 pages, 55 pages and 19 pages. The hearing transcript was 121 pages. Claimant testified on her own behalf and there were two defense witnesses. Claimant's attorney did not submit a statement of services.

We agree with the ALJ that the medical record was more complex than average, considering the range of cases generally submitted to this forum. The claim's value and the interest involved were average. The attorneys presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions and the employer's vigorous defense, there was a significant risk that claimant's counsel's efforts might have gone uncompensated. Considering all these factors, we find that an appropriate fee for services at hearing regarding compensability of the bilateral tendinitis condition is $3,200.

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

Attorney Fee/Board Review

Claimant's attorney is also entitled to an assessed fee for services on review regarding the employer's compensability denial of the bilateral tendinitis condition. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's services on review regarding the bilateral tendinitis compensability denial is $1,200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated November 4, 1998 is affirmed in part and modified in part. That portion of the order awarding an assessed attorney fee of $4,200 is modified. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded a fee of $3,200 for services at hearing concerning compensability of the bilateral tendinitis condition and $1,000 for services at hearing and on review concerning responsibility of the same condition, to be paid by the self-insured employer. The remainder of the order is affirmed. For services on Board review regarding the compensability of the bilateral tendinitis condition, claimant's counsel is awarded a $1,200 attorney fee, to be paid by the employer.

In the Matter of the Compensation of
GLORIA G. HARTVIGSEN, Claimant
WCB Case No. 97-02338
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denial of her injury claim for a lumbosacral strain and sacroiliac ligament tear. In its brief, SAIF contends that the ALJ erred in admitting a post-hearing document in evidence. On review, the issues are evidence and compensability.

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

In the sixth paragraph on page 2, we change the last sentence to read: "Although claimant's husband testified that he had observed claimant demonstrate the exercise she had performed to the emergency room doctor on November 10, 1996 (Tr. 83), Dr. Douglas reported that claimant did not recall any specific injury while at work. (Ex. 2)."

In the second full paragraph on page 3, we change the fourth sentence to read: "Claimant's testimony is supported by existence of the backward bending exercise on the employer's video and the exercise documents."

Evidence

SAIF argues that the ALJ erred in allowing an unauthorized document (Exhibit AA) to be admitted after the record closed. We need not address SAIF's evidentiary argument because, even if we disregard Exhibit AA, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused her discretion by admitting Exhibit AA. *See Mario F. Torres*, 49 Van Natta 2074 (1997); *Larry D. Poor*, 46 Van Natta 2451 (1994).

Compensability

The ALJ found that, because claimant did not sustain her burden of proving legal causation, the question of medical causation was moot. For the following reasons, we find that, even if we were to conclude that legal causation had been established, we would find that claimant has failed to establish medical causation.

In *Barnett v. SAIF*, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert testimony of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, we find that the circumstances of claimant's injury claim are complicated. Although claimant testified that she experienced low back pain after performing a stretching exercise on November 6, 1996, she did not report the injury to her supervisor until November 10, 1996. Claimant first sought medical treatment in the emergency department on November 10, 1996 from Dr. Douglas, who reported that claimant did not recall any specific injury while at work. (Ex. 2). Furthermore, Dr. Ballman, who treated claimant on November 12, 1996, reported that it was medically improbable that claimant would have such a protracted injury and course of events related to an injury from a stretching exercise. (Ex. 11C). Dr. Ballman's report in particular supports a finding that the situation is complicated. Under these circumstances, we conclude that an expert medical opinion is necessary to determine the causation of claimant's lumbosacral strain and sacroiliac ligament tear.

We find no medical evidence that claimant had a preexisting condition that combined with her work injury. Consequently, claimant need only prove that the November 6, 1996 work injury was a material cause of the lumbosacral strain and sacroiliac ligament tear. ORS 656.005(7)(a).

Claimant contends that she injured her back performing a stretching exercise at work on November 6, 1996. Four days later, Dr. Douglas reported that claimant did not recall any specific injury while at work, although she mentioned that she performed stretching exercises before starting work. (Ex. 2).

On November 12, 1996, claimant was treated by Dr. Ballman, who reported that claimant had injured herself at work by doing stretching exercises on November 6, 1996. (Ex. 5). In later report, Dr. Ballman said that it was "possible" that claimant could have strained her back doing stretching exercises, but he felt it was "medically improbable that she would have such a protracted injury and course of events related to that degree of injury." (Ex. 11C). He concluded that it was "unlikely that a condition lasting this period of time would be reasonable after such a rather unimpressive stretch or intercurrent strain." (*Id.*)

Claimant was treated by Dr. Otten beginning on November 20, 1996. (Ex. 7). He reported that claimant believed she might have triggered the back pain with pre-shift stretching. (*Id.*) In a "check-the-box" letter from claimant's attorney, Dr. Otten agreed that claimant's "stretching exercises and/or the work activities of a custodian" were the major contributing cause of her lumbosacral strain. (Ex. 11D). In a report to SAIF, however, Dr. Otten indicated he did not believe claimant's injury was related to the stretching exercise. Dr. Otten wrote to SAIF that the back pain diagnosed by Dr. Douglas on November 10, 1996 was only "possibly" related to the stretching she performed on November 6, 1996. (Ex. 12). Dr. Otten felt that it was "more probable than not" that claimant's current back pain was *not* caused by the alleged November 6, 1996 injury.[1] (*Id.*)

Dr. Hill examined claimant on August 4, 1997, almost eight months after her work injury. (Ex. 15). On August 18, 1997, he diagnosed persistent lumbar back pain "of unclear etiology." (Ex. 15A). On January 26, 1998, Dr. Hill reported to claimant's attorney that it "would appear that the lumbar strain occurred in association with stretching exercises at work." (Ex. 19A-2).

Dr. Karasek treated claimant on November 13, 1997 with a lumbar steroid injection and he performed a discography on January 6, 1998. (Exs. 16, 18A). On January 13, 1998, he reported to claimant's attorney that a probable lumbosacral strain occurred with exercise. (Ex. 18-2).

When the medical evidence is divided, we generally give more weight to those opinions that are both well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Although claimant relies on the opinions of Drs. Hill and Karasek, neither of them examined her until at least eight months after the work injury. They both felt that claimant's low back injury was associated with stretching exercises. However, neither physician discussed what stretching exercise caused claimant's low back condition, nor did either of them explain how that exercise actually caused the injury. Moreover, neither Dr. Hill nor Dr. Karasek addressed Dr. Ballman's opinion that it was medically improbable that claimant would have such a protracted injury related to a stretching exercise. We are not persuaded by the conclusory opinions of Drs. Hill or Karasek because they are not well-reasoned. We conclude that claimant has failed to sustain her burden of proving medical causation.

ORDER

The ALJ's order dated September 23, 1998 is affirmed.

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[1] In his later report, Dr. Otten made no further comments as to whether claimant's work activities in general caused her back condition. We note that claimant does not rely on that theory of compensability. In any event, we are not persuaded by Dr. Otten's conclusory "check-the-box" opinion that claimant's "stretching exercises and/or the work activities of a custodian" were the major contributing cause of her lumbosacral strain. (Ex. 11D).

In the Matter of the Compensation of
VIRGIL R. WHITTEKIEND, Claimant
WCB Case No. 98-05206
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that determined that the issue of claimant's entitlement to temporary disability from February 21, 1996 to September 4, 1996 was properly raised during the reconsideration proceeding. On review, the issue is jurisdiction.

We adopt and affirm the ALJ's order.

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 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 October 29, 1998 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

Board Member Moller dissenting.

The majority adopts and affirms the ALJ's holding that claimant is not barred from litigating his entitlement to temporary disability from February 21, 1996 through September 4, 1996. In so doing, it affirms the ALJ's conclusion that claimant properly raised the issue during reconsideration proceedings, as required by statute. Because I would conclude that, on reconsideration, claimant was contesting a different period of time loss, I respectfully dissent.

It is first necessary to briefly recount the factual and procedural background of the claim. Claimant compensably injured his low back on November 6, 1995. A left foot condition was later found compensable in March 1997. The foot claim was closed by a March 11, 1998 Notice of Closure that awarded temporary disability from September 5, 1996 through the medically stationary date of January 20, 1998.

Claimant requested reconsideration. On a Department-generated "request for reconsideration" form, claimant checked a box indicating that he disagreed with the temporary disability dates shown on the closure order, but he did not complete a section of the form indicating what the proper dates should be. (Ex. 21-3). In a cover letter to which the reconsideration request form was attached, claimant stated that he disagreed with the medically stationary date because his compensable condition was not medically stationary. Claimant then wrote: "For the same reasons we disagree with the temporary disability dates. Disability should continue." (Ex. 21-1).[1]

The Order on Reconsideration affirmed the temporary disability award in the Notice of Closure. Claimant requested a hearing. On his initial request for hearing form, claimant indicated that he was requesting a hearing regarding the Order on Reconsideration. However, he left blank a space in which to indicate whether substantive time loss was an issue and, if so, in which to indicate the period of time loss sought. Subsequently, one week prior to the scheduled hearing, claimant filed an amended hearing request attempting to expressly raise substantive entitlement to temporary disability from February 21, 1996 through September 4, 1996.

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[1] *See Lebanon Plywood v. Seiber*, 113 Or App 651 (1992) ("Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date.")

In response to the insurer's argument that claimant did not raise the temporary disability issue *in the reconsideration proceedings* as statutorily required, the ALJ found that claimant raised the issue of his "entire" temporary disability award by indicating his disagreement with the temporary disability dates in his reconsideration request. Thus, the ALJ held that claimant was not barred from litigating entitlement to temporary disability from February 21, 1996 through September 4, 1996.

Having set forth the background of the claim, I now proceed with my analysis. ORS 656.268(8) states that: "No hearing shall be held on any issue that was not raised and preserved before the department at reconsideration." ORS 656.283(7) provides that "issues that were not raised by a party to the reconsideration may not be raised at hearing." ORS 656.726(3)(g) grants the Director of the Department of Consumer and Business Services with the authority to prescribe procedural rules for proceedings pursuant to ORS Chapter 656 regarding all matters other than those specifically allocated to the Board or the Hearings Division. The reconsideration process is such a proceeding. OAR 436-030-0125(1)(c) requires that a completed reconsideration request include "the specific reason(s) for objection to the Determination Order or Notice of Closure."

The question in this case is whether claimant's reconsideration request sufficiently complied with the above statutes and administrative rule such that he could litigate his entitlement to temporary disability for a period prior to the medically stationary date. I conclude that it did not.

Considered by itself, claimant's completed reconsideration request form is ambiguous. Claimant indicated that he disagreed with the temporary disability dates in the Notice of Closure, but he did not specify what dates he thought were proper, even though space was provided for him to do so. However, any ambiguity in the reconsideration request form itself is dispelled by reference to the letter to which it was attached.[2] There, claimant clearly stated his belief that his condition was not medically stationary and that, for this reason, his disability should continue. Therefore, the most reasonable interpretation of claimant's reconsideration request is that the temporary disability dates being contested related solely to those subsequent to the medically stationary date (January 20, 1998). Claimant simply did not raise entitlement to the earlier period in his reconsideration request.

Accordingly, the ALJ's conclusion (as affirmed by the majority) that the reconsideration request raised the issue of temporary disability for a period much earlier than the medically stationary date is overbroad and contravenes the intent of the legislature that an issue be first raised during reconsideration proceedings. Because of this, I must part company with the majority and dissent.

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[2] We are not called upon to determine whether claimant's completed request for reconsideration form alone would sufficiently comply with the statutes and administrative rules so that he could raise his "entire" temporary disability award as an issue at hearing. The form was not submitted alone; rather it was submitted as an enclosure to the more specific narrative letter.

March 2, 1999 Cite as 51 Van Natta 350 (1999)

In the Matter of the Compensation of
PEDRO FRIAS, Claimant
WCB Case No. C9-00418
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lavis, et al, Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On February 16, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

The CDA provides for a partial release of temporary disability benefits. On page 4, the CDA reserves claimant's rights to temporary disability benefits at issue in a proceeding before the Court of Appeals. Specifically, the CDA provides, on page 4, lines 7 through 11, that:

"The proceeding now before the Court of Appeals in case number A101756 regarding the rate of claimant's temporary disability *shall not be stayed*, but shall continue to final conclusion for the purpose of determining the rate at which the one week of past temporary total disability compensation excluded from the Disposition shall be payable." (Emphasis supplied.)

ORS 656.236(1)(a) provides, in pertinent part, that: "Submission of a disposition shall stay all other proceedings and payment obligations, except for medical services, on that claim." Thus, in accordance with that statute, the court proceeding regarding the temporary disability rate issue has been stayed from the date of the submission of the CDA to the Board until our approval. *See* OAR 438-009-0030. Because the CDA expressly provides that claimant's right to pursue the temporary disability rate issue has been reserved, we have interpreted the aforementioned provision as further confirmation that the litigation of that issue may proceed (now that the statutory "stay" has been lifted).

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' CDA is approved. An attorney fee of $5,875, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

March 2, 1999 Cite as 51 Van Natta 351 (1999)

In the Matter of the Compensation of
CURTISS N. SMITH, Claimant
WCB Case No. 98-05203
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Claimant requests reconsideration of our February 2, 1999 Order on Review, in which we affirmed the Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of his left knee injury claim. Citing *Thomas C. Clark*, 50 Van Natta 2428 (1998), claimant again argues that SAIF's denial should be set aside at least to the extent that he suffered a compensable left knee strain. We disagree.

In *Clark*, we set aside the carrier's denial to the extent that it included a diagnosed contusion. 50 Van Natta 2430. *Clark*, however, did not involve a "combined condition." By contrast, the medical evidence here establishes that the January 1998 work incident combined with a preexisting left knee condition at the outset. (Exs. 20-2, 31-2). Therefore, unlike *Clark*, this case involves compensability under ORS 656.005(7)(a)(B). *See Charles L. Grantham*, 48 Van Natta 1094 (1996). Because we agree with the ALJ's reasoning that the preexisting left knee condition is the major contributing cause of claimant's need for treatment and disability, we also concur with the ALJ's finding that the claim is not compensable under ORS 656.005(7)(a)(B).

Accordingly, we withdraw our February 2, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our original 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
JOSEPH L. YEANEY, Claimant
WCB Case No. 98-06241
ORDER ON REVIEW
Schneider, 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) Davis' order that awarded an assessed attorney fee of $3,000. SAIF also moves for remand. On review, the issues are remand and attorney fees.

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

Attorney Fees

After finding that claimant's right knee injury was compensable, the ALJ awarded an assessed attorney fee under ORS 656.386(1). The ALJ considered the factors set forth in OAR 438-015-0010(4) and found that a reasonable fee amount for services at hearing was $3,000. The ALJ noted that claimant's attorney was an established practitioner with a recognized emphasis in workers' compensation. The ALJ found that the circumstances of the injury were somewhat confusing and SAIF provided a vigorous defense.

On review, SAIF contends that, under *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), the ALJ's order is insufficient with regard to the attorney fee award. SAIF contends that the ALJ was required to make specific findings of fact for each of the factors in OAR 438-015-0010(4)[1] and, because the order failed to do so, asks the Board to vacate and remand.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to merely describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See McCarthy*, 327 Or at 188; *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, because the ALJ indicated that he had considered the factors in OAR 438-015-0010(4) in assessing the fee, we find the order, as well as the record, sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.

In addition to the ALJ's discussion, we note the following. The hearing lasted one and one-half hours. The record consisted of 21 exhibits. The compensability issue was of average complexity. The benefit secured for claimant also appears to be average. In light of the circumstances of the injury, there was a risk claimant's attorney would go uncompensated. Both attorneys were experienced and skillful. Finally, there is no assertion of frivolous issues or defenses. Based on the factors in OAR 438-015-0010(4), we agree with the ALJ that $3,000 is a reasonable attorney fee. Finally, claimant's attorney is not entitled to an attorney fee for defending the attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated November 27, 1998 is affirmed.

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[1] In determining a reasonable attorney fee, the rule requires the ALJ to consider the following factors: (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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

In the Matter of the Compensation of
PEGGY ZAMORA, Claimant
WCB Case No. 98-04941
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that dismissed her hearing request as untimely filed insofar as it pertained to the insurer's February 26, 1998 denial. On review, the issue is dismissal.

We adopt and affirm the ALJ's order with the following supplementation regarding the sufficiency of claimant's June 19, 1998 request for hearing.

On February 26, 1998, the insurer denied claimant's claim. Although claimant's attorney's request for hearing raised "compensability" as an issue, it referred only to the insurer's May 13, 1998 denial. The June 19, 1998 request for hearing was received by the Board on June 22, 1998.

On July 2, 1998, a Notice of Hearing was mailed to claimant, claimant's attorney, and the insurer. In its August 11, 1998 response to issues, the insurer's counsel's response to issues stated that the February 26, 1998 denial was not timely appealed. Claimant's attorney did not thereafter file a request for hearing on the February 26, 1998 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). Here, the ALJ found that claimant failed to meet his obligation to timely appeal the February 26, 1998 denial.

On review, claimant argues that his June 19, 1998 request for hearing satisfied that obligation, citing *Darlene L. Vanover*, 47 Van Natta 672 (1995), and *Ralph E. Fritz*, 44 Van Natta 1168 (1992). We disagree.

Claimant's reliance on *Vanover* and *Fritz* are inapposite. In *Vanover*, the claimant's request for hearing identified "any and all" denials, compensability, temporary partial disability, temporary total disability, and failure to pay temporary total disability as the issues to be litigated at hearing. In *Fritz*, the claimant identified temporary partial disability, temporary total disability, penalties and attorney fees, and entitlement to compensation as the issues to be litigated at hearing. In both cases, the jurisdictional issue was not based on any deficiencies in the hearing requests, but on whether the Hearings Division had jurisdiction over the issue of entitlement to interim compensation on a claim accepted as nondisabling. We held in each case that the claimant's request for hearing raised the issue of entitlement to interim compensation and that, therefore, the Hearings Division had jurisdiction over the issue of procedural entitlement to temporary disability.

In contrast to the facts in the cases cited by claimant, the hearing request upon which claimant relies did not identify the February 26, 1998 denial as an issue in any manner. Therefore, we conclude that claimant did not timely request a hearing on the denial.

ORDER

The ALJ's order dated October 15, 1998 is affirmed.

In the Matter of the Compensation of
RONALD P. OLSON, Claimant
Own Motion No. 98-0119M
OWN MOTION ORDER
Popick & Merkel, Claimant Attorneys
Williams & Fredrickson, Defense Attorneys

On June 5, 1998, we authorized reopening of claimant's claim for the payment of temporary disability compensation beginning February 2, 1998. Claimant requests enforcement of our June 5, 1998 order, contending that the self-insured employer had unilaterally terminated his temporary disability benefits. Specifically, claimant requests reinstatement of his benefits, as well as penalties and attorney fees for unreasonable claim processing.

In response, the employer contends that: (1) the work restrictions imposed on claimant in the May 5, 1998 work release are the same restrictions imposed in a 1981 Determination Order and a 1986 Physical Capacities Evaluation; (2) claimant has not returned for his follow-up visit with his attending physician; and (3) claimant "himself has determined that his condition has reached maximum medical improvement." For these reasons, the employer asserts that claimant is not entitled to temporary disability compensation beyond the May 5, 1998 work release and that penalties and attorney fees are not warranted.[1]

Entitlement to Temporary Disability Compensation

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4).

Here, claimant's claim has not been closed nor has a claim disposition agreement been filed pursuant to ORS 656.236(1). Rather, it appears that the employer terminated claimant's temporary disability compensation partially based on claimant's failure to seek medical treatment. While the Department does have rules that allow such termination of benefits under ORS 656.268(3)(d) and ORS 656.262(4)(e), there are no similar provisions for termination of benefits in an Own Motion claim pursuant to ORS 656.278. *See generally Brian K. Lutz*, 49 Van Natta 2009 (1997); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Pamela Vinyard*, 48 Van Natta 1442 (1996). Rather, as noted, termination of temporary disability benefits in a claim reopened under ORS 656.278 can only occur when a claimant is medically stationary or when a CDA extinguishes a claimant's right to further temporary disability compensation or termination of such benefits is authorized under ORS 656.268(3)(a) through (c). *See* OAR 438-012-0035(4).

Further, the employer argues that because claimant was released to work with restrictions similar to those imposed in a 1981 Determination Order and a 1986 Physical Capacities Evaluation, then essentially he was released to full duty. Relying on ORS 656.268(3)(b), the employer contends that Dr. Hayes' May 5, 1998 report released claimant to regular employment and thus it was justified in terminating temporary disability benefits. We disagree.

Here, Dr. Hayes specifically released claimant to *modified* work and opined that he could return to *most* types of work. Considering that Dr. Hayes' opinion refers to a "modified work" release, we are not persuaded that claimant was released to regular work.

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[1] With its response, the employer submitted what appeared to be an original of a September 24, 1998 Notice of Closure which declared claimant medically stationary as of May 5, 1998. Pursuant to OAR 438-012-0055, when the employer closes a claimant's claim, it shall issue a Notice of Closure (Form 2066) to the claimant with copies to the claimant's attorney, if any, and Benefits Section. The employer acknowledges that it did not submit a copy of the Notice of Closure to the Department, *i.e.* the Benefits Section. Inasmuch as the "claim closure" requirements of OAR 438-012-0055 have not been satisfied, we review this temporary disability issue as a procedural (pre-closure) issue, rather than a substantive (post-closure) issue.

When a claimant is released to modified duty, the applicable criteria for terminating temporary disability compensation is found in ORS 656.268(3)(c), which states that a physician must advise claimant and document in writing that he is released to modified employment, that such employment is offered in writing to claimant and that claimant fails to begin such employment. *See generally Anthony R. Holder*, 50 Van Natta 1760 (1998). The record before us does not indicate that claimant was offered, in writing, modified employment and that he failed to begin such employment. Thus, we find that the necessary criteria has not been met and that claimant's temporary disability compensation should not have been terminated. Accordingly, we conclude that claimant is entitled to further temporary disability compensation beginning May 5, 1998, to continue until such benefits can be lawfully terminated.

Penalties and Attorney Fees

Claimant requests penalties and attorney fees for the employer's allegedly unreasonable claims processing and failure to pay compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due." The employer's refusal to pay compensation is not unreasonable if it has a legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras*, 103 Or App 65 (1990).

Here, our June 5, 1998 order authorized temporary disability to be paid until the employer could lawfully terminate such benefits. The question becomes whether the circumstances on which the employer based its termination of claimant's benefits provided it with a legitimate doubt regarding its continuing liability to pay such benefits.

On this record, we are not persuaded that the employer had a legitimate doubt regarding its continued obligation to pay compensation on claimant's own motion claim in accordance with our prior order. As previously noted, we do not consider a release to "modified work" to constitute a release to "regular work." Moreover, the employer does not offer a reasonable explanation of its reliance on the criteria of a statute (ORS 656.268(3)(d)) which has been determined inapplicable in claims under our own motion jurisdiction. *See Frank L. Bush*, 48 Van Natta 1744 (1996) (Application of ORS 656.268(3)(d), which allows termination of temporary disability compensation under the criteria found in ORS 656.262(4), is not permissible in claims reopened under our own motion authority pursuant to ORS 656.278). In other words, the employer offers no statutory, regulatory or case authority to support its interpretation of Dr. Hayes' release to modified duty as a release to full duty.

Therefore, under ORS 656.262(11)(a), we find that the employer's termination of claimant's temporary disability benefits was unreasonable. Consequently, claimant is entitled to a 25 percent penalty of the amounts "then due" a result of our order, payable in equal shares to claimant and his attorney. *See John R. Woods*, 48 Van Natta 1016 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991).

Accordingly, the employer is directed to recommence temporary disability compensation beginning May 5, 1998 when it terminated compensation until it can lawfully terminate such benefits. The penalty assigned by this order shall be based on the unpaid temporary disability compensation made payable by this order between May 5, 1998 and the date of this order.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA C. PECK, Claimant
Own Motion No. 97-0077M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Rasmussen & Tyler, Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests review of the insurer's August 12, 1998 Notice of Closure which closed her claim with an award of temporary disability compensation from March 3, 1997 through April 27, 1998. The insurer declared claimant medically stationary as of April 27, 1998. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed and specifically requests a review of the "appropriate dates for which time loss was awarded in this Notice of Closure."

In an October 16, 1998 letter, we requested the insurer to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on December 10, 1998. Claimant has not submitted a response to the insurer's submission. Therefore, 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 she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 12, 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 April 27, 1998, claimant was examined by Dr. Clark, an insurer-arranged medical examiner (IME). Dr. Clark opined that, although claimant still had persistent joint pain secondary to the surgery, claimant was medically stationary and that her condition would not improve over a period of time. Dr. Garber, claimant's attending physician, concurred with the IME report. These opinions are unrebutted.

The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure. Inasmuch as temporary disability benefits were paid through April 27, 1998, the date she was declared medically stationary, we conclude that claimant is not entitled to additional temporary disability and that it was appropriately terminated. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's August 12, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA A. WILLIAMS, Claimant
Own Motion No. 98-0251M
OWN MOTION ORDER
Nina Robart, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable 1989 low back strain injury. Claimant's aggravation rights expired on April 13, 1995.

SAIF opposes authorization of temporary disability compensation, contending that: (1) the current condition is not causally related to the accepted condition; (2) SAIF is not responsible for claimant's current condition; and (3) surgery or hospitalization is not reasonable or necessary.

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

On June 12, 1998, the Board postponed action to allow resolution of litigation pending before the Hearing Division. On December 1, 1998, Administrative Law Judge (ALJ) Podnar issued an Opinion and Order upholding SAIF's denial of claimant's February 2, 1998 "new injury" claim regarding the compensability of her current L5-S1 disc condition. ALJ Podnar's order did not address how claimant's current L5-S1 disc herniation related, if at all, to claimant's 1989 injury.

Following ALJ Podnar's order, the Board requested the parties' positions regarding claimant's request for own motion relief concerning her 1989 injury claim. SAIF represents that the compensability of claimant's current L5-S1 disc herniation is undetermined. Specifically, SAIF asserts that claimant has not formally requested acceptance or denial of this "new medical condition" (left-sided L5-S1 disc herniation), for which she sought treatment. Claimant has neither responded to SAIF's representations nor to the Board's request.

Under these circumstances, we conclude that the compensability of the condition which is the basis of claimant's own motion claim remains unresolved. Based on this conclusion, we are not authorized to reopen claimant's 1989 injury claim for the payment of temporary disability benefits.[1] *See* ORS 656.278(1)(a). Should claimant's current condition subsequently be accepted or determined to be compensably related to the accepted strain injury in the 1989 claim, claimant may again seek own motion relief.

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

Claimant's entitlement to medical expenses for her accepted condition under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] Our jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. Jurisdiction to decide matters of compensability, responsibility or the propriety of surgery or hospitalization (for post-1966 injuries) rests either with the Hearings Division pursuant to ORS 656.283 or with the Director under ORS 656.245, 656.260 or 656.327. *See Gary L. Martin*, 48 Van Natta 1802 (1996).

In the Matter of the Compensation of
ANNIE L. BOUNDS, Claimant
WCB Case No. 97-10293
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld the insurer's denial of her current cervical condition; (2) determined that her claim was not prematurely closed; (3) declined to assess penalties for the insurer's allegedly unreasonable denial and unreasonable resistance to the payment of compensation; and (4) declined to award attorney fees. On review, the issues are compensability, premature closure, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Medical records indicated that claimant was treated in 1975, 1978, 1980, 1981 and 1991 for neck and shoulder pain. (Exs. A-J). On October 25, 1980, she was diagnosed with a "chronic cervical strain." (Ex. D). A May 31, 1981 report indicated that claimant had a 5 year history of neck/ upper back/ left shoulder pain. (Ex. F). A June 1, 1981 report referred to "DJD" at C5-6 with "disc space narrowing spurs." (Ex. H).

Claimant, a certified nursing assistant, was injured on September 9, 1997, when she was transferring a patient from a bed to a wheelchair. (Ex. 2). She was diagnosed with a cervical and trapezius strain. (Ex. 3). Radiological tests showed cervical degenerative disease and osteophytes from C4 through C7. (Ex. 5). Claimant was released to modified work on September 16, 1997. (Ex. 6). She was treated by Dr. Lawlor on several occasions through December 8, 1997. Claimant's treatment included physical therapy and medication.

Dr. Lawlor reported that a cervical MRI on October 2, 1997 showed multilevel advanced changes of degenerative disc disease at C4-5, C5-6 and C6-7, localized lateral recessed narrowing at C5-6 on the right and decreased foraminal space bilaterally at C4-5 and C6-7. (Ex. 11). Electrodiagnostic studies were normal. (Ex. 12).

On October 27, 1997, claimant was examined by Drs. Sacamano and Gardner on behalf of the insurer. (Ex. 14). They found that claimant had preexisting degenerative cervical disc disease, which they felt might be retarding her recovery. (Ex. 14-5). They believed that her injury had combined with the degenerative condition and they anticipated that the cervical strain would diminish in the next 2 to 4 weeks and become a minor contributing cause of her treatment and disability. (*Id.*) They believed claimant's accepted condition would be medically stationary in 2 to 4 weeks. (Ex. 14-6). Dr. Lawlor basically concurred with their report, except that she felt it would take longer than 2 to 4 weeks for claimant to be medically stationary. (Exs. 16, 17, 37-42).

On November 18, 1997, Dr. Lawlor reported that claimant's slow rate of improvement from the cervical sprain was due to her preexisting cervical degenerative disc disease. (Ex. 17). On December 2, 1997, Dr. Lawlor agreed that claimant's current condition was now the result of her preexisting degenerative cervical disc disease rather than the cervical strain. (Ex. 18).

On December 3, 1997, the insurer accepted a nondisabling cervical strain, which was later changed to a disabling claim. (Exs. 19, 25). On December 8, 1997, the insurer denied claimant's current condition on the basis that her current need for treatment and/or disability was due to preexisting cervical degenerative disc disease. (Ex. 21).

Claimant began treating with Dr. Jura on December 12, 1997 and he became her attending physician. (Exs. 22, 23). Dr. Jura's treatment included chiropractic therapy and spinal manipulation. (Ex. 30-2).

A Notice of Closure issued on December 18, 1997, awarding temporary partial disability. (Ex. 27). Claimant requested reconsideration. (Ex. 28). On February 21, 1998, a medical arbiter examination was performed by Drs. Becker, Kho and Vessely. (Ex. 28C). They found that claimant's decreased cervical range of motion was related to preexisting degenerative cervical disease. (Ex. 28C-4). They did

not find any loss of residual functional capacity from the accepted condition. (Ex. 28C-6). A March 10, 1998 Order on Reconsideration affirmed the December 18, 1997 Notice of Closure. (Ex. 31). In response to claimant's request for reconsideration, the Department withdrew the March 10, 1998 Order on Reconsideration. (Ex. 34). An Order on Reconsideration issued on March 20, 1998, again affirming the December 18, 1997 Notice of Closure. (Ex. 35).

Claimant requested a hearing on the insurer's December 8, 1997 denial, as well as the March 1998 Orders on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ found that claimant's cervical strain condition combined with her degenerative disc disease. The ALJ concluded that claimant did not meet her burden of proving that the accepted cervical strain was the major contributing cause of her current cervical condition.

Claimant argues that a combined condition did not exist. She contends that Dr. Lawlor had not declared that a combined condition existed at any time before issuance of the current condition denial. Claimant argues that the insurer's denial is invalid under ORS 656.262(7)(b).

For the following reasons, we are not persuaded by claimant's argument that the insurer's denial was invalid under ORS 656.262(7)(b). In *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998) (decided after the ALJ's order), 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 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 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.

Here, the insurer denied claimant's current condition on the basis that her current need for treatment and/or disability was due to preexisting cervical disc disease. (Ex. 21). At hearing, claimant argued that the insurer's denial was not a "major contributing cause" denial, but rather a current condition denial. (Tr. 7). The insurer's attorney acknowledged that the denial did not contain "major cause" language, noting that its position was that the compensable cervical strain was no longer the major cause of the combined condition. (Tr. 8). Although the insurer argued that claimant's argument was a "distinction without a difference" (Tr. 9), the ALJ allowed the insurer to amend its denial to assert that the compensable condition was no longer the major cause of the disability or need for treatment. (Tr. 13-15).

To the extent claimant is raising the issue of the insurer's amended denial on review, we find that the insurer was not precluded from amending its denial at hearing. In *SAIF v. Ledin*, 149 Or App 94 (1997), the court clarified that a carrier may amend its denial at hearing. Our rules expressly provide that amendments to the issues raised and relief requested at hearing "shall be freely allowed." OAR 438-006-0031, OAR 438-006-0036. Where such an amendment is permitted, to afford due process, the responding party must be given an opportunity to respond to the new issues raised. OAR 436-006-0091(3); *Sandra M. Goodson*, 50 Van Natta 1116 (1998). A party's remedy for surprise and prejudice created by a late-raised issue is a motion for continuance. OAR 438-006-0031, OAR 438-006-0036; OAR 438-006-0091.

In this case, claimant's attorney objected to the amended denial, but did not request a continuance. (Tr. 15). Rather, claimant's attorney said that the "amended language" would be appealed. (*Id.*) There is no indication that claimant was surprised or prejudiced by the insurer's argument that the compensable cervical strain was no longer the major cause of the combined condition. Claimant does not contend that he was surprised or prejudiced by these issues and did not request a continuance. Instead, at hearing, claimant submitted evidence, testimony, and argument regarding all of these issues. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue); *Sandra M. Goodson*, 50 Van Natta at 1117 (carrier was allowed

to amend its response to the claimant's hearing request and raise affirmative defenses at hearing). Therefore, we proceed to the merits.[1]

Based on the *Blamires* case, the insurer's denial in this case is procedurally proper if the medical evidence establishes that claimant's cervical strain combined with any preexisting condition(s). The resolution of this issue involves 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). Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983).

To begin, we find that, contrary to claimant's assertion, Dr. Lawlor's reports issued before the insurer's December 8, 1997 denial indicated that claimant had a combined condition. Claimant was treated by Dr. Lawlor from September 17, 1997 to December 8, 1997. Dr. Lawlor reported that a cervical MRI on October 2, 1997 showed multilevel advanced changes of degenerative disc disease at C4-5, C5-6 and C6-7, localized lateral recessed narrowing at C5-6 on the right and decreased foraminal space bilaterally at C4-5 and C6-7. (Ex. 11). Dr. Lawlor reported on November 18, 1997 that claimant's slow rate of improvement from her cervical sprain was due to the preexisting cervical degenerative disc disease. (Ex. 17). On the same date, Dr. Lawlor agreed with the October 27, 1997 report from Drs. Sacamano and Gardner, which indicated that claimant's injury had combined with the degenerative condition. (Exs. 14, 16, 17). On December 2, 1997, Dr. Lawlor agreed that claimant's current condition was now the result of the preexisting degenerative cervical disc disease rather than the cervical strain. (Ex. 18). We interpret Dr. Lawlor's reports to mean that claimant's cervical strain injury combined with the preexisting cervical degenerative disease to cause or prolong her disability or need for treatment.

Furthermore, the subsequent medical opinions established that claimant had a "combined" condition. In a concurrence letter from the insurer's attorney, Dr. Lawlor agreed that claimant had severe cervical degenerative disc disease that preexisted her September 9, 1997 injury and her treatment was caused by a combination of the injury and the preexisting degenerative disc disease. (Ex. 29-1, -2). She adhered to that opinion in a deposition. (Ex. 37-47). Dr. Lawlor testified that the medical treatment and medication she recommended on December 8, 1997 was prescribed in major part because of symptoms produced by the cervical degenerative disc disease. (Ex. 37-45, -46).

Claimant was also treated by Dr. Jura beginning December 12, 1997, three months after the work injury. His treatment included chiropractic therapy and spinal manipulation. (Ex. 30-2). His initial chart note commented that "[i]t is important to note that the patient had no prior problems with her neck, no symptoms, no neck pain, no prior medical treatment or radiological diagnoses." (Ex. 23-1). He had not seen any x-rays or the MRI and he noted only that claimant had "[s]ome kind or amount of degenerative disc disease by history or radiological diagnosis. No symptoms or medical diagnosis prior, however." (Ex. 23-2).

In a concurrence letter with claimant's attorney, Dr. Jura agreed that, based on the history provided by claimant, "there were no clinically significant symptoms in the neck region" before the September 1997 injury and he did not believe it was medically reasonable to conclude that claimant suffered from significant degenerative disc disease. (Ex. 30-2). He agreed there was no "objective indication" that the cervical strain combined with preexisting degenerative changes. (*Id.*)

Medical records indicated that claimant was treated in 1975, 1978, 1980, 1981 and 1991 for neck and shoulder pain. (Exs. A-J). On October 25, 1980, she was diagnosed with a "chronic cervical strain." (Ex. D). A May 31, 1981 report indicated that claimant had a 5 year history of neck/ upper back/ left shoulder pain. (Ex. F). A June 1, 1981 report referred to "DJD" at C5-6 with "disc space narrowing spurs." (Ex. H). Dr. Jura, however, reported that claimant had no prior problems with her neck and no symptoms or medical treatment. (Ex. 23-1). Because Dr. Jura's opinion was based on an inaccurate history, it is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977). Moreover, we find no evidence that Dr. Jura had reviewed claimant's 1997 cervical MRI, which showed multilevel advanced changes of degenerative disc disease at C4-5, C5-6 and C6-7. (Ex. 37-76). Under these circumstances, we are not persuaded by his conclusory opinion that there was no "objective indication" that the cervical strain combined with preexisting degenerative changes. (Ex. 30-2).

[1] Our conclusion should not be interpreted as a determination that, in the absence of the amendment at hearing, the insurer's denial would have been procedurally invalid.

Based on the opinions of Drs. Lawlor, Sacamano and Gardner, we find that claimant's September 9, 1997 injury combined with preexisting cervical degenerative disc disease to cause her disability or need for treatment. Based on these medical opinions, we conclude that ORS 656.005(7)(a)(B) applies to this case. As we noted earlier, the insurer amended its denial at hearing, asserting that claimant's compensable cervical strain was no longer the major cause of the combined condition. ORS 656.262(7)(b)[2] applies to this case and we must examine the medical evidence to determine whether claimant's current cervical condition is compensable.

On December 2, 1997, Dr. Lawlor agreed that claimant's current condition was now the result of her preexisting degenerative cervical disc disease rather than the cervical strain. (Ex. 18). In a concurrence letter from the insurer's attorney, Dr. Lawlor agreed that claimant had severe cervical degenerative disc disease that preexisted her September 9, 1997 injury and her need for treatment was caused by a combination of the injury and the preexisting degenerative disc disease. (Ex. 29-1, -2). She adhered to that opinion in a deposition. (Ex. 37-47). She agreed that the major cause for claimant's need for treatment after December 8, 1997 was the preexisting degenerative joint disease and not the cervical strain. (Ex. 37-64, -65).

Dr. Lawlor's opinion is supported by the report from Drs. Sacamano and Gardner. They had examined claimant on October 27, 1997 and believed that her injury had combined with the degenerative condition and they anticipated that the accepted cervical strain would diminish in the next 2 to 4 weeks and become a minor contributing cause of her treatment and disability. (Ex. 14-5). Dr. Lawlor's opinion is also supported by the report from the medical arbiter panel, which related claimant's decreased cervical range of motion to her preexisting degenerative cervical disease. (Ex. 28C-4).

On the other hand, Dr. Jura agreed with claimant's attorney that the major contributing cause for claimant's need for treatment with him was the September 1997 work injury. (Ex. 30-2). We are not persuaded by Dr. Jura's opinion because it was based on an inaccurate history that claimant had no prior neck problems or medical treatment. In addition, there is no evidence that Dr. Jura had reviewed claimant's 1997 cervical MRI and we are not persuaded that he adequately weighed the relative contribution of the work injury as compared to the preexisting cervical degenerative disc disease. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995). Dr. Jura did not explain why he believed that claimant's work injury contributed more to her current cervical condition than the preexisting degenerative condition.

In sum, we agree with the ALJ that claimant did not sustain her burden of proving that the September 9, 1997 work injury is the major contributing cause of her current disability and need for treatment.

Premature Closure

The ALJ found that claimant was not medically stationary at the time of claim closure. Nevertheless, she found that the claim was not prematurely closed because the accepted injury was no longer the major contributing cause of claimant's combined condition. *See* ORS 656.268(1)(a).

Claimant argues that the medical opinions establish that further improvement was expected in her condition with medical treatment and the passage of time and, therefore, claim closure was inappropriate. She relies on the testimony of Dr. Lawlor and Dr. Jura's report. Claimant also contends that the insurer's "current condition" denial did not authorize claim closure under OAR 436-030-0034.

For the following reasons, we agree with claimant that her condition was not medically stationary at the time of claim closure.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether the insurer prematurely closed this claim depends on whether claimant was medically stationary at the time

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[2] ORS 656.262(7)(b) provides that "[o]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

of the December 18, 1997 Notice of Closure, without consideration of subsequent changes in her condition. *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985). Claimant has the burden of proving, by competent medical evidence, that her condition was not medically stationary at the time of closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624, 628 (1981).

The insurer accepted a nondisabling cervical strain, which was later changed to a disabling claim. (Exs. 19, 25). The December 18, 1997 Notice of Closure indicated claimant was medically stationary on December 8, 1997. (Ex. 27).

Claimant changed her attending physician to Dr. Jura on December 12, 1997. (Ex. 22). In a concurrence letter from claimant's attorney, Dr. Jura agreed that claimant's cervical strain was not medically stationary when he began treating her in December 1997, although he expected her to be stationary "soon." (Ex. 30-1). His concurrence letter was signed on March 9, 1998.

Claimant had been examined by Drs. Sacamano and Gardner on October 27, 1997. (Ex. 14). They felt that claimant would be medically stationary in 2 to 4 weeks, which would occur by the end of November 1997. (Ex. 14-6). On November 18, 1997, Dr. Lawlor basically concurred with their report, although she felt it would take longer than 2 to 4 weeks for claimant to become medically stationary. (Exs. 16, 17). In a deposition, Dr. Lawlor testified that she had last treated claimant on December 8, 1997. (Ex. 37-32). At that time, she felt that claimant would be medically stationary in 2 to 4 weeks. (Ex. 37-30, -32). Dr. Lawlor hoped that claimant would have some minor improvement in her cervical strain. (Ex. 37-44).

OAR 436-030-0035(1) (WCD Admin. Order 96-052) provides that a worker's compensable condition shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other comparable language. Here, claimant was treated by two physicians and the evidence from both Dr. Jura and Dr. Lawlor establishes that claimant was not medically stationary at the time of the December 18, 1997 Notice of Closure. On the other hand, Drs. Sacamano and Gardner felt that claimant would be medically stationary by the end of November 1997. (Ex. 14-6). We are not persuaded by their opinion, however, because they examined claimant on only one occasion and their report suggests only the possibility that she would become medically stationary in November 1997. We are more persuaded by the opinions of Drs. Jura and Lawlor because they had an opportunity to treat claimant over a period of time.

The insurer argues, alternatively, that claim closure was appropriate because the accepted injury was no longer the major cause of claimant's current condition. The insurer relies on ORS 656.262(7)(b), ORS 656.268(4) and OAR 436-030-0034(3).

Under ORS 656.268(1)(a), a claim can be closed without the worker's condition being medically stationary 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. Similarly, OAR 436-030-0034(3) provides that a claim may be closed when the worker is not medically stationary and a "major contributing cause denial has been issued." The rule further provides:

> "(a) The major contributing cause denial shall inform the worker that claim closure will result from the issuance of the denial and other information required by these rules;
>
> "(b) When a 'major contributing cause' denial has been issued, the date the claim qualifies for closure shall be the date the insurer receives information sufficient to determine the extent of any permanent disability pursuant to OAR 436-035-0007(4) or the date of the denial, whichever is later."

It is well-established that notice given by a carrier must be in strict compliance with the applicable rule in order for the administrative closure to be proper. *Paniagua v. Liberty Northwest Ins. Corp.*, 122 Or App 288 (1993); *Martha E. Leyva*, 49 Van Natta 1177 (1997). When a rule specifically and unambiguously requires the carrier to follow a certain procedure, substantial compliance is not sufficient. *SAIF v. Robertson*, 120 Or App 1 (1993); *Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991); *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986).

ORS 656.262(7)(b) provides that "[o]nce a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." Administrative closure under OAR 436-030-0034(3) only applies when the worker is not medically stationary and "a major contributing cause denial has been issued." Here, the insurer's denial provided, in part:

> "You filed an injury claim for cervical strain which allegedly occurred on or about 9/9/97 while employed by [the employer].
>
> "Your claim has been accepted for a cervical strain and all benefits paid accordingly. We have recently received information that your current need for treatment and/or disability is no longer the accepted condition but now due to your pre-existing degenerative cervical disc disease.
>
> "Therefore, without waiving further questions of compensability we respectfully issue this denial of compensability for any treatment or disability in connection with your current condition. The issuance of this denial will result in closure of your claim. This specific denial should not be considered a waiver of any other affirmative defenses to your claim." (Ex. 21).

Although the insurer's denial indicated it was denying claimant's current need for treatment because it was no longer related to the accepted condition, but was "due to [her] pre-existing degenerative cervical disc disease," the denial made no reference to "major contributing cause" or a "combined condition." The insurer's denial did not strictly comply with OAR 436-030-0034(3), which requires that "a *major contributing cause denial* has been *issued*." (Emphasis added). Although the insurer amended its denial at hearing to refer to the fact that the accepted injury was no longer the major contributing cause of the disability or need for treatment, the insurer did not issue a "written denial" to that effect, as required by OAR 436-030-0034(3). Because the insurer did not "issue" a "major contributing cause" denial, we find that the insurer failed to strictly comply with the applicable rules in closing the claim. Consequently, we conclude that the insurer's administrative closure was improper. Accordingly, we set aside the March 10, 1998 and March 20, 1998 Orders on Reconsideration and the December 18, 1997 Notice of Closure as premature.

Penalties

The ALJ found that, because the denial and claim closure were appropriate, there was no basis to award a penalty.

Claimant argues that the insurer's denial was unreasonable. 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).

At the time of the insurer's December 8, 1997 denial, the insurer had reports from Dr. Lawlor, claimant's then-treating physician, indicating that claimant's current need for treatment was due to a preexisting degenerative condition. Dr. Lawlor reported on November 18, 1997 that claimant's slow rate of improvement from her cervical sprain was due to the preexisting cervical degenerative disc disease. (Ex. 17). On the same date, Dr. Lawlor agreed with the October 27, 1997 report from Drs. Sacamano and Gardner, which indicated that claimant's injury had combined with the degenerative condition. (Exs. 14, 16, 17). On December 2, 1997, Dr. Lawlor agreed that claimant's current condition was now the result of the preexisting degenerative cervical disc disease rather than the cervical strain. (Ex. 18). In light of Dr. Lawlor's references to the fact that claimant's current need for treatment was due to cervical degenerative disease, we conclude that the insurer had a legitimate doubt as to its liability for claimant's current cervical condition. Therefore, we do not assess a penalty against the insurer for an unreasonable denial.

Claimant also contends that, by issuing a "current condition" denial and issuing an improper Notice of Closure, the insurer unreasonably resisted the payment of time loss and the payment of medical treatment expenses with Dr. Jura.

We are not persuaded that the insurer unreasonably resisted the payment of compensation by issuing the December 18, 1997 Notice of Closure. The Orders on Reconsideration issued on March 10, 1998 and March 20, 1998 determined that the claim qualified for closure pursuant to OAR 436-030-0034(3) and ORS 656.268(4)(a). (Exs. 31-2, 35-2). Although we have determined that the administrative closure was improper, we do not find the issue to have been so clear that the insurer acted unreasonably by closing the claim. *See, e.g., Ernest C. Vroman*, 49 Van Natta 809 (1997) (issue was not so clear that the carrier acted unreasonably in recalculating the claimant's temporary total disability rate based on prior Board case law); *Marie E. Kendall*, 46 Van Natta 2520 (1994), *on recon* 47 Van Natta 335 (1995) (carrier's conduct held reasonable where case law at the time supported propriety of that conduct). Under these circumstances, we conclude that claimant is not entitled to a penalty.

ORDER

The ALJ's order dated October 16, 1998 is reversed in part and affirmed in part. The Orders on Reconsideration and Notice of Closure are set aside as premature and the claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded an "out-of-compensation" attorney fee equal to 25 percent of any additional temporary disability compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. The remainder of the ALJ's order is affirmed.

March 4, 1999 Cite as 51 Van Natta 364 (1999)

In the Matter of the Compensation of
SUSAN K. COX, Claimant
WCB Case No. 98-05952
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Snarskis, Yager, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's injury claim for a right lateral meniscus tear. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 47 at the time of hearing, works for the employer as a grocery checker. On January 7, 1997, she sought treatment for pain and "locking" in her right knee. At that time, claimant advised Dr. Boswoth that she had noted the vague onset of symptoms in her right knee about nine months prior, but the pain had "gotten much worse" over the last three months. Dr. Bosworth diagnosed mild patellofemoral and tibiofemoral degenerative arthritis. The doctor injected the knee with cortisone and local anesthetic, and recommended anti-inflammatories and physical therapy.

Sixteen months later, on May 18, 1998, claimant experienced a pop and immediate, excruciating pain in her right knee as she got up from a chair in the employee break room. She had finished eating her lunch and was getting up to return to work when her knee locked up. She was unable to stand or bear weight on the knee, and she did not complete her shift.

Claimant sought treatment the next day and was diagnosed with an acute knee sprain. An x-ray showed no acute injury. Claimant was thereafter referred to Dr. Rubinstein, who diagnosed a displaced lateral meniscus tear. A May 27, 1998 MRI of the right knee showed small effusion, a tear along the posterior horn of the lateral meniscus with meniscal displacement into the intracondylar notch and mild bone bruise in the lateral femoral condyle.

On June 1, 1998, Dr. Rubinstein performed surgery, a right knee arthroscopy, lateral meniscus repair and debridement. Surgical findings included chondral loose bodies throughout the knee, mild synovitis, diffuse grade 3 chondral changes on the undersurface of the patella, a significant chondral injury involving the medial femoral condyle on weight-bearing surface and the lateral femoral condyle with a groove missing from the lateral femoral condyle that appeared to be associated with lateral meniscus tear that was displaced.

On July 7, 1998, claimant was evaluated by Dr. Mayhall at the insurer's request. After reviewing claimant's medical records, including the May 27, 1998 MRI report and Dr. Rubinstein's surgical findings, Dr. Mayhall concluded that the May 18, 1998 tearing of the lateral meniscus was a "spontaneous, more-or-less idiopathic event rather than the result of a work 'injury.'" Dr. Mayhall further reported that, to the extent the incident was considered a work injury, the incident combined with claimant's preexisting degenerative arthritis and inherent body factors and was not the major cause of claimant's disability or need for treatment.

In a July 17, 1998 report, Dr. Rubinstein disputed Dr. Mayhall's conclusions, noting that, as claimant arose from the chair at work, she "may have had some torsion or increased stress to the knee and meniscus" that caused the tear and displacement. Recognizing that claimant had underlying weakening that may have predisposed the meniscus to tearing, Dr. Rubinstein referred to the event at work as "the straw that broke the camel's back."

On October 7, 1997, claimant was evaluated by Dr. Farris at the insurer's request. Dr. Farris concluded that because claimant's lateral meniscus tear occurred during the relatively innocuous activity of arising from a chair, the major contributing cause of the tear was the significant, preexisting degenerative condition in the right knee rather than the incident at work. Dr. Farris also opined that, given claimant's history of knee pain and locking, including her January 1997 visit to Dr. Bosworth, claimant probably had a tear of the lateral meniscus prior to the May 17, 1998 incident. Dr. Farris concluded that the May 17, 1998 incident simply caused the meniscus to displace into the preexisting notch, and the incident was not the major contributing cause of claimant's disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Rubinstein, the ALJ concluded that the May 17, 1998 incident at work was the major contributing cause of claimant's disability and need for treatment. On review, the insurer contends that claimant has not sustained her burden of proof under ORS 656.005(7)(a)(B). Specifically, the insurer argues that Dr. Rubinstein's opinion does not satisfy the major contributing cause standard and is insufficient to establish compensability. We agree with the insurer.

Both Dr. Mayhall and Dr. Farris opined that the degenerative changes in claimant's right knee preexisted the May 17, 1998 incident and that the preexisting condition contributed significantly to claimant's meniscal tear. Even Dr. Rubinstein conceded that claimant had preexisting degenerative changes, which may have included some weakening within the menisci themselves. Given this evidence, we are persuaded that claimant's meniscal tear involves a "combined condition." Therefore, under ORS 656.005(7)(a)(B), claimant must establish that the May 17, 1998 incident was the major contributing cause of her disability or need for treatment of the combined condition.

Determining the "major contributing cause" of the disability or need for treatment of claimant's combined condition involves evaluating the relative contribution of different causes of an injury or disease (including claimant's preexisting degenerative condition) 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.* The "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, although Dr. Rubinstein used the "magic words," we find his opinion insufficient under the *Dietz v. Ramuda* standard. Dr. Rubinstein's explanation, *i.e.*, that the May 17, 1998 incident "was the straw that broke the camel's back," establishes only that the at-work event was the precipitating event, not the major contributing cause, of claimant's disability or need for treatment. Indeed, unlike Drs. Mayhall and Farris, who explained that the act of arising from a chair is a trivial and non-traumatic

event that would not ordinarily result in a torn meniscus, Dr. Rubinstein did not weigh the relative contribution of claimant's preexisting degenerative changes and explain his rationale for naming the incident at work as the major cause. In addition, Dr. Rubinstein did not respond to Dr. Farris' contention that claimant's prior history of locking and effusion[1] strongly suggested that the tear actually predated the May 17, 1998 incident, and that the incident only caused the meniscus to displace into the preexisting notch. Finally, Dr. Rubinstein assumed that claimant's meniscal tear resulted from some unusual twisting or torquing of the knee when she got up from the chair, but this scenario is not supported by the record. Claimant testified she could not recall whether she stood up straight or turned; she just remembered the onset of immediate pain that caused her to return to a seated position. For these reasons, we find Dr. Rubinstein's opinion unpersuasive. *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); *see also Moe v. Ceiling Systems*, 44 Or App 429 (1980).

Accordingly, we conclude that claimant has not established by a preponderance of the evidence that the May 18, 1998 incident at work was the major contributing cause of her disability or need for treatment of the combined knee condition.[2]

ORDER

The ALJ's order dated November 18, 1998 is reversed. The insurer's denial of claimant's right lateral meniscus tear is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

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[1] For example, claimant advised Dr. Bosworth in January 1997 that her right knee occasionally locked up and that she had occasional swelling. (Ex. 1). On her initial visit to Dr. Rubinstein on June 1, 1998, claimant reported that, about one year prior to the incident on May 18, 1998, she felt something pop in her knee and it locked up for a few hours. (Ex. 8).

[2] As in *Robinson v. SAIF*, 147 Or App 157 (1997), this is not a case where there is a difference between the major contributing cause of the need for treatment of claimant's combined condition and the major contributing cause of the combined condition itself. *Compare SAIF v. Nehl*, 148 Or App 101 (1997).

In the Matter of the Compensation of
MAGGIE L. GIBSON, Claimant
WCB Case No. 98-02262
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 9, 1999 Order on Review that, in part, affirmed the Administrative Law Judge's (ALJ's) attorney fee award of $3,000. SAIF contends that we "abused [our] discretion in awarding an attorney fee greater than that submitted in claimant's attorney's statement of services." According to SAIF, "the highest fee that should be allowed in this case is $2,247.50, as reflected in claimant's attorney's statement of services." In support of its argument, SAIF cites to *SAIF v. Severson*, 105 Or App 67 (1990).

In *Severson*, the claimant's attorney's statement of services requested an assessed fee of "$425+" and the Board awarded $500. Citing ORS 656.388 and OAR 438-015-0010(4), the court decided that the Board abused its discretion in awarding a higher fee. 105 Or App at 73.

We find *Severson* distinguishable from this case. There, the claimant's attorney submitted the statement of services to the ALJ, thus taking the position at hearing that a fee of "$425+" should be awarded. Here, as claimant explained on review, her attorney asked for $3,000 at hearing.[1] Although the statement of services (submitted to the Board on review) provided a fee of $2,247.50, we understand

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[1] According to claimant, this request was made during unrecorded closing arguments. SAIF does not challenge this assertion.

it to be a catelog of the time devoted to the case multiplied by a certain hourly wage. Consequently, we consider the statement of services to be based only on the time devoted to the case. Because claimant asked for a fee of $3,000 at hearing and sought affirmance of the $3,000 award on review, we find that this fee is the one requested by claimant's attorney.

As explained in our order, the time devoted to the case is only one factor that we consider in awarding a reasonable attorney fee. Consequently, because the fee contained in the statement of services is based only on hours devoted to the case, it is one factor among others that we examined in determining a reasonable attorney fee. As our order also states, after considering *all* the factors provided in OAR 438-015-0010(4), we found that a reasonable fee in this case for claimant's attorney's services at hearing was $3,000. We continue to adhere to that reasoning and conclusion.[2]

Accordingly, we withdraw our February 9, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our February 9, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] We also note that SAIF raised this issue for the first time on reconsideration. In its reply brief, SAIF stated: "SAIF's argument is also not that the fee may be too high." Moreover, SAIF's argument on reconsideration is inconsistent with its previous contention that, in light of claimant's attorney's newly-submitted statement of services, the "issue then becomes whether the other factors that are required to be considered justify a greater fee than that reflected in the statement of services." (SAIF's reply brief, p. 2).

In the Matter of the Compensation of
THOMAS P. HARROW, Claimant
WCB Case No. C9-00369
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
John M. Hoadley, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On February 11, 1999, 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.[1]

The first page of the agreement recites that claimant shall receive a total consideration of $250, and claimant's attorney shall receive $750. We conclude that the first page of the agreement is in error and that the attorney fee and the amount payable to claimant have been inadvertently transposed. Thus, we find that the parties' intent is for the settlement proceeds to be distributed as follows:

$250.00 Total Due Attorney
$750.00 Total Due Claimant[2]

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' CDA is approved. An attorney fee of $250, payable to claimant's counsel, is also approved.

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[1] Two claims were resolved by the CDA. Because the other CDA met the criteria for approval, it has been approved. Notice of that approval has been provided by postcards.

[2] We note that the CDA provides for an attorney fee consistent with *amended* OAR 438-015-0052(1) which limits attorney fees payable from CDAs to 25 percent of the first $17,500 of agreement proceeds plus 10 percent of any amount of proceeds in excess of $17,500. Our interpretation of the CDA is consistent with the attorney fee rule.

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.

March 4, 1999 Cite as 51 Van Natta 368 (1999)

In the Matter of the Compensation of
WALDTRAUT M. McRORIE, Claimant
WCB Case No. 98-00485
ORDER ON REVIEW
Hilary E. Berkman, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its partial denial of claimant's situational adjustment reaction and shingles conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has worked at the employer's store in Albany for over 20 years. During that time, she has worked in several departments. In April 1997, claimant transferred to the janitorial department, which was designated as the Building Service Maintenance Department [BSM]. BSM consisted of five to six employees, but staffing is not at that level during all shifts because the BSM employees work differing shifts and days. The jobs in BSM are rotated among the workers so the same person is not doing the same job all the time. (Tr. 117). Sometimes jobs outside of specific BSM job descriptions were assigned because Mr. Bergstedt, the new director at the Albany store, was trying to bring that store up to his standards. Mr. Miller is claimant's immediate supervisor, and Mr. Johnson, served as supervisor in Mr. Miller's absence.

Since about 1994, claimant has had chronic rheumatoid arthritis, which was brought under control with medications. Claimant is not making a claim for her rheumatoid arthritis condition or her preexisting osteoarthritis of the hands condition.

Claimant's husband is an alcoholic; however, claimant reported that she has come to terms with that. (Tr. 52-53). Claimant treated briefly with Dr. Cutner, psychiatrist, for marital problems in the past. About three years ago, claimant's husband, who works as a janitor at the employer's store in Corvallis, had an affair with a co-worker there. That co-worker now works as a janitor at the employer's store in Salem. Since the affair ended, the co-worker has "stalked" claimant and her husband. In 1997, claimant started keeping a calendar recording the co-worker's "stalking" activities, which include parking outside of claimant's home and watching her and her husband, driving by their house, and following them in her car. (Tr. 18, 32-34, 84). The co-worker also called claimant's husband and told him that she had left him her inheritance. (Tr. 34). Claimant heard that the co-worker told workers in the Albany and Salem stores that claimant physically abused her husband. (Tr. 35).

The co-worker lives about two miles from claimant's house in Albany, and claimant believes that every day the co-worker goes to the Corvallis store where claimant's husband works. (Tr. 35). Claimant also believes that the co-worker goes to the Albany store almost every day she (the co-worker) is not working. (Tr. 36).

Both the police and Mr. Bergstedt have advised claimant that she could get a restraining order against the co-worker. (Tr. 60-61, 83-84). Claimant decided against doing that.

Mr. Miller and Mr. Johnson know the co-worker. Claimant has seen the co-worker's car parked in front of Mr. Miller's house in Albany and has seen Mr. Miller driving the co-worker's vehicles. (Tr. 36-37). She has also seen Mr. Miller and Mr. Johnson talking with the co-worker in the parking lot of the Albany store before their shift started. Claimant has reported all of these observations to Mr. Bergstedt. (Tr. 91).

Claimant believes that the co-worker is trying to take her position in BSM at the Albany store. She also believes that the co-worker's friendship with Mr. Miller and Mr. Johnson influences them against her.

Claimant has had multiple conversations with Mr. Bergstedt about the co-worker and claimant's concern that the co-worker will be hired at the Albany store. (Tr. 37-38, 73, 75, 82, 91). Mr. Bergstedt has repeatedly told claimant that he is in charge of hiring and the co-worker will not be hired at the Albany store. (Tr. 38, 81, 83, 96, 97).

On September 15, 1997, claimant sustained a compensable left shoulder contusion with associated muscle spasms. The claim was accepted for "contusion to left shoulder." (Ex. 19).

The day of the injury, claimant was taken off work by Dr. Weeks, her family physician for the last 20 years. (Ex. 3, 4). Claimant wanted to take vacation rather than being taken off work as she had already planned on taking vacation at that time. But Mr. Miller and Mr. Johnson turned down her vacation request. (Tr. 12-13). She then took her vacation request to Mr. Bergstedt, who granted it.

On September 22, 1997, Dr. Weeks examined claimant and released her to return to work on September 25, 1997, with restrictions of no work with her arm above shoulder level and no repetitive internal and external rotation of her shoulder, such as mopping. She was permitted to lift, push and pull loads up to 50 pounds occasionally and 20 pounds frequently. (Ex. 5, 5A). Claimant's restrictions were limited to her injured left shoulder. (Tr. 27). Claimant is right-handed, and she had no restrictions regarding her right arm and shoulder. (Tr. 27). She was able to do repetitive work with her right arm and hand and use them above shoulder level. (Tr. 27).

Claimant felt intimidated by Mr. Miller and Mr. Johnson. (Tr. 16). She was concerned that Mr. Miller and Mr. Johnson would retaliate against her for going over their heads with her request for vacation and because they were friends with the co-worker who had an affair with her husband. Prior to returning to modified work, she spoke to Mr. Bergstedt about this and about her restrictions. Mr. Bergstedt offered her a choice of doing modified work on BSM or changing to one of the light-duty jobs the employer had available. (Tr. 71-72). Claimant chose to stay on the BSM job. While on modified work, claimant was not assigned a specific BSM position. (Tr. 118). Instead, Mr. Bergstedt and claimant decided what BSM jobs were within her restrictions, such as vacuuming, cleaning mirrors, dusting, sweeping, which were duties that were not repetitive on her restricted left side. (Tr. 27, 40, 71, 101, 118).

Prior to claimant's returning to modified work, Mr. Bergstedt informed Mr. Miller and Mr. Johnson about claimant's work restrictions and her concern about retaliation. (Tr. 73-74, 80-81). He told them there would be no retaliation. (Tr. 105-106).

The first day claimant returned to modified work, she was assigned to wash the walls/stalls in the rest rooms in preparation for repainting. When cleaning the rest rooms, claimant held the cleaner in one hand and the wet cloth in the other hand to wipe down the walls/stalls. (Tr. 28, 30). Claimant washed walls/stalls only on the first day of modified work and worked a total of three days at modified work. Claimant believed that Mr. Miller and Mr. Johnson exceeded her restrictions in assigning her the walls/stalls washing job and gave her less time to do her assigned jobs than they gave other workers.

On September 28, 1997, claimant sought treatment at the Emergency Room for pain in her back, left shoulder, and right arm, with swelling in the right wrist and hand. (Ex. 7A-4). The diagnosis was "multiple joint pains with history of rheumatoid arthritis." (*Id.*).

On September 29, 1997, claimant saw Dr. Weeks. (Ex. 22, Tr. 46). On October 6, 1997, Dr. Weeks examined claimant and diagnosed shingles, situational adjustment reaction with anxiety and sleep disturbance, and rheumatoid arthritis, in remission. (Ex. 10). Dr. Weeks treated claimant for those conditions on October 20, 1997 and October 27, 1997, and released her to regular duties on the latter date. (Exs. 12, 14). Dr. Weeks released claimant from work from September 29, 1997 until October 30, 1997. (Exs. 8, 9, 11, 13, 15).

On November 19, 1997, Dr. Turco, psychiatrist, examined claimant on behalf of the employer and found no evidence of any psychiatric disorder, secondary gain, or deception. (Ex. 16). That same date, Drs. Bonafede, rheumatologist, and Woodward, orthopedist, examined claimant on behalf of the

employer. (Ex. 17). They found that claimant's left shoulder disability was due to the work injury and was medically stationary. They gave no opinion regarding the cause of the shingles condition or the psychiatric condition.

On December 22, 1997, as amended at hearing, the employer denied situational adjustment reaction and shingles conditions as unrelated to the September 15, 1997 work injury. (Ex. 18).

On January 16, 1998, the employer closed the left shoulder injury claim with an award of temporary disability only. (Ex. 20).

On January 22, 1998, Dr. Weeks concurred with Dr. Turco's report. (Exs. 16, 21). On April 3, 1998, Dr. Weeks issued a causation opinion. (Ex. 22).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that Exhibit 22, which is Dr. Weeks' April 3, 1998 causation opinion, was admitted at hearing, although the ALJ inadvertently omitted that exhibit from his listing of the admitted exhibits. (Tr. 3).

The ALJ found, and claimant agrees, that Dr. Weeks' opinion establishes compensability of her situational adjustment reaction and shingles conditions. The employer argues that Dr. Weeks' opinion does not meet claimant's burden of proving major causation. We agree with the employer.

Here, claimant contends that her situational adjustment reaction and shingles conditions were caused by stress created by her immediate supervisors upon her return to modified work. Specifically, claimant contends that her immediate supervisors assigned her work (the walls/stalls washing job) that exceeded the physical restrictions placed on her due to her compensable left shoulder injury.[1] In addition, claimant contends that, upon her return to modified work, her immediate supervisors gave her less time to do her assigned jobs than they gave other workers. Claimant contends that the motive for these actions was the alleged animosity her immediate supervisors held towards her because she went over their heads in requesting vacation and because they were friends with her husband's ex-lover. Thus, it appears that claimant's primary argument is that her situational adjustment reaction and shingles conditions are consequential conditions related to her compensable left shoulder injury.

Subsequent to the ALJ's order, we held that, when analyzing the compensability of a mental condition alleged to be related to a compensable injury, the applicable standard is the "consequential condition" standard under ORS 656.005(7)(a)(A),[2] not the "mental disorder" standard under ORS

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[1] It is not clear on this record that the walls/stalls washing job exceeded claimant's restrictions. In this regard, claimant was right-handed and had no restrictions on the use of her uninjured right arm and shoulder. Claimant's restrictions were limited to her injured left shoulder and consisted of no work with her left arm above shoulder level and no repetitive internal and external rotation of her left shoulder. (Ex. 5, 5A, Tr. 27). Claimant testified that she held the cleaner to squirt the walls/stalls in one hand and the wet cloth in the other hand to wipe down the walls/stalls. (Tr. 15, 28, 30). She also testified that she could not wash the walls/stalls with one hand. (Tr. 29-30). But she was not restricted from using her left hand. Mr. Bergstedt testified that, given Dr. Weeks' restrictions, he saw no reason claimant could not do the walls/stalls washing job using her right arm. (Tr. 111). Nevertheless, we need not address claimant's contentions regarding whether the modified work exceeded her restrictions or whether she was given shorter time frames than other workers to complete assigned tasks, because even accepting claimant's allegations as fact, for the reasons addressed below, we conclude that she failed to meet her burden of proof regarding the major contributing cause issue.

[2] ORS 656.005(7)(a)(A) provides, in relevant part:

"(7)(a) A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death * * * if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

656.802(3).[3] *Jackie T. Ganer*, 50 Van Natta 2189 (1998), *on recon* 51 Van Natta 116 (1999).[4] Nevertheless, whether a mental condition is analyzed under ORS 656.802 or ORS 656.005(7)(a)(A), claimant has the burden of proving that the employment conditions or the compensable injury were the major contributing cause of the mental condition. ORS 656.005(7)(a)(A); ORS 656.266; ORS 656.802(2)(a). Because claimant must establish major contributing cause under either standard, we first address whether she has met that burden of proof.

Determining the "major contributing cause" of claimant's situational adjustment reaction and shingles conditions 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), *review dismissed* 321 Or 416 (1995). 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).

Because of the multiple areas of stress in claimant's life, including the fact that she and her husband have been "stalked" by her husband's ex-lover for the last three years, the major cause of claimant's situational adjustment reaction and shingles conditions presents 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). We generally defer 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. Weeks' opinion.

Dr. Weeks provides the only opinion that might support compensability of claimant's situational adjustment reaction and shingles conditions. Dr. Weeks noted that, on September 29, 1997, claimant returned tearful and distraught and, although Dr. Weeks found no objective evidence of worsening of claimant's arthritis or her work injury, he found her to be more uncomfortable than her prior visit on September 22, 1997. (Ex. 22-1). Claimant reported that "she had been required to perform work that was outside the range of her restrictions[,] that was in excess of her usual duties and that she felt it was assigned to her as punishment by her two most immediate supervisors in retribution for her going 'above their heads' with another matter." (*Id.*). [Claimant testified that this "other matter" was the request for vacation time she made to Mr. Bergstedt after her immediate supervisors refused that request].

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[3] ORS 656.802(3) provides:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

"(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

[4] *See Boeing Co. v. Viltrakis*, 112 Or App 396 (1992) (if a claim for a mental disorder is brought as an *independent* claim, it must be brought under ORS 656.802 as a claim for an occupational disease; however, if the condition results from a compensable injury, it may be treated as a claim for the consequences of an injury); *Aetna Casualty C. v. Robinson*, 115 Or App 154 (1992) (regardless of whether the onset is gradual or sudden, a mental condition that results directly from work is treated as an independent claim governed by ORS 656.802 and a mental condition that results from a compensable injury is treated as a claim for the consequences of an injury); *compare Fuls v. SAIF*, 321 Or 151 (1995) (the claimant's condition did not involve a consequential mental condition; Court held because the sole condition for which the claimant sought compensation was a "mental disorder," his claim was not compensable, pursuant to the unambiguous terms of ORS 656.802(3), unless he satisfied paragraphs (a) through (d) of that subsection).

Dr. Weeks noted that, on October 6, 1997, claimant was seen again, was again tense and tearful, and had developed a rash consistent with shingles. (*Id.*). He noted that stress is "known to be a precipitating cause for shingles." (*Id.*). He concluded that:

> "a major contributing cause to [claimant's] increased joint pain, anxiety, sleep disturbance, and shingles was the situational stress caused by her employment, specifically the conduct of her 2 immediate supervisors and the duties assigned to her that were outside the limits of her restrictions at that time. Although there are other causes of stress outside [claimant's] employment, she had been coping well with these up until the conflict with her immediate supervisor which occurred in September of '97. Since that conflict has been resolved, she has done well and has returned to performing her usual duties without difficulty." (Ex. 22-1-2).

Claimant contends that Dr. Weeks' opinion meets her burden of proof, contending that, as her long-time attending physician, he was aware of her stresses outside of work and eliminated them as the cause of her mental condition and shingles. Although we agree that, as claimant's long-time attending physician, Dr. Weeks was in a good position to know of and determine the contribution of claimant's stresses inside and outside of work, he did not apply that knowledge in his causation opinion. In order to meet the major contributing cause standard, Dr. Weeks had to evaluate the relative contribution of the different causes of the shingles and the mental conditions and decide which was the primary cause. *Dietz*, 130 Or App at 401. Dr. Weeks did not do that. Instead, he found that, although claimant had outside stressors, she was able to cope before and after the work stress, so the work stressors were a major contributing cause of her mental condition and shingles. As the Court of Appeals has recognized, the "precipitating cause" is not necessarily the "major contributing cause." *Id.* All that Dr. Weeks' opinion establishes is that the work stress was the "precipitating cause," it does not establish that it was the major contributing cause. *See Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Furthermore, Dr. Weeks' statement that the work stress was "a" major contributing cause does not establish that the work stress was the primary cause, *i.e.*, "the" major contributing cause.[5] Moreover, although a physician is not required to use "magic words" in a medical report, given the problems with Dr.Weeks' opinion addressed above, we do not find that Dr. Weeks' opinion as a whole meets claimant's burden of proof. *See Arnold D. Schaffer*, 47 Van Natta 1667, 1670 (1995) (considering physician's opinion as a whole, opinion that injury was "a" major contributing cause did not establish causation); *James L. Curtis*, 45 Van Natta 396 (1993) (same).

No other medical opinion supports claimant's claim. Therefore, we find that claimant has failed to meet her burden of proof.

ORDER

The ALJ's order dated May 18, 1998 is reversed. The employer's partial denial of the situational adjustment reaction and shingles conditions is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[5] Dr. Weeks' statement that work stress was "a major contributing cause" came in response to an inquiry from claimant's counsel as to whether work stress was "the major contributing cause." (Ex. 22-3).

In the Matter of the Compensation of
EVELYN A. BURSELL, Claimant
WCB Case No. 98-06865
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the insurer's denial of claimant's current right knee condition; and (2) declined to award penalties for an allegedly unreasonable denial. On review, the issues are propriety of the denial, compensability, and penalties.

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

The last sentence of the fourth full paragraph on page two is modified to indicate that Dr. Brennecke was "unable to identify the major cause of the current condition and did *not* think the work injury was the major contributing cause." (Ex. 12).

We do not adopt the paragraph beginning on page 3 and ending on page 4 (or note 1).

Claimant argues that the insurer's August 21, 1998 current right knee condition denial is precluded by a March 10, 1998 Opinion and Order that directed the insurer to accept claimant's combined right knee condition (involving a March 16, 1995 right knee strain and preexisting nonwork related degenerative joint disease).

Even assuming, without deciding, that claimant's current right knee condition is the same as the condition previously determined to be compensable (or that the issue now is the same as it was then[1]), we would agree with the ALJ that the insurer's August 1998 denial was procedurally and substantively proper. We reach this conclusion because the medical evidence indicates that claimant's compensable injury had ceased to be the major contributing cause of her combined right knee condition when the August 21, 1998 denial issued. *See Florella E. Connor*, 50 Van Natta 414 (1998); *see also Gregory C. Noble*, 50 Van Natta 1469, 1470 (1998) (ORS 656.262(6)(c) "specifies the situation where a second proceeding is not precluded by the finality of the first proceeding, *i.e.*, where the compensable injury ceases to be the major contributing cause of the combined condition.")

ORDER

The ALJ's order dated December 16, 1998 is affirmed.

[1] This is not the same claim as at the prior hearing, because there is evidence now that the work injury ceased to be the major contributing cause of the combined condition *since* the prior compensability determination. *Compare Sylvia Eberlie*, 49 Van Natta 1095 (1997) (Where the claimant's condition had not changed since the prior ALJ's order *and* there was no evidence since the prior order that the work injury ceased to be the major cause of the condition, the employer could not avoid the preclusive effect of the prior order); *Katherine A. Wood*, 48 Van Natta 2196 (1996) (same); *Robert Mendez*, 48 Van Natta 1100 (1996) (Denial precluded where there was no change in the operative facts after a stipulated agreement accepting the claim.)

In the Matter of the Compensation of
TOBY R. KINZINGER, Claimant
WCB Case No. 98-02648
ORDER ON RECONSIDERATION
Westmoreland & Mundorff, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our February 5, 1999 Order on Review that reversed the Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's left hip injury claim and assessed an attorney fee of $3,500. In requesting reconsideration, claimant disagrees with our conclusion that the opinion of claimant's current treating physician, Dr. Voeller, was not sufficiently persuasive to carry claimant's burden of proving compensability.

Claimant first notes that we characterized Dr. Voeller's opinion as being a "letter from claimant's attorney" when *Roseburg Forest Products v. Glenn*, 155 Or App 318 (1998), holds that attorney-generated medical reports are entitled to the same evidentiary consideration as reports provided directly from the physician.

As the court explained in *Glenn*, whatever the form of a medical opinion, it is to be evaluated on the same terms as a report prepared by the doctor. 155 Or App at 321. An opinion that lacks explanation or foundation may be discounted, but not for the reason that it is expressed as an adoption or concurrence. *Id.* Here, although our order noted that Dr. Voeller's opinion was provided by a "letter from claimant's attorney," we did not rely on this rationale for finding it unpersuasive. Instead, we found that Dr. Voeller provided insufficient explanation for finding a causative relationship between claimant's left hip symptoms and the June 1997 work incident.

Claimant further contends that the order "ignores" testimony from the employer corroborating "claimant's fall in the shop at the time of the accident." We note that we did not find Dr. Voeller's opinion unpersuasive because he relied upon an inaccurate history but for lack of sufficient explanation to support his conclusion.

Finally, for the reasons provided in the order, we disagree with claimant's contention that "there are no persuasive reasons not to defer to Dr. Voeller's opinion."

Accordingly, we withdraw our February 5, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our February 5, 1999 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
DENISE STOLTZ, Claimant
WCB Case No. 97-09162
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of cervical, right shoulder and thoracic degenerative conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant has worked for the employer since 1980 as a travel trailer assembler. Prior to her employment, she had no neck, shoulder or back problems. (Tr. 5). Her work required the use of a driver, nail guns and staple guns, lifting cabinets and mattresses and, for the past 12 years, frequent overhead work with her neck extended. (Tr. 5 through 9). Claimant sought chiropractic treatment for a sore mid-back in July 1993, a sore right shoulder in December 1993, and a sore neck beginning in August 1995. (Ex. A, Tr. 8, 9).

On July 16, 1997, claimant sought emergency room treatment for severe thoracic and right shoulder pain that arose the previous night when she was at home after work. Subsequent examination revealed right shoulder swelling and decreased range of motion in the neck. Several weeks later, after MRI studies, Dr. Walker diagnosed degenerative disc disease in the cervical and thoracic areas, including herniated discs at C4-5, C5-6 and C6-7 with impingement, and T4-5 and T5-6 forminal stenosis with impingement. (Exs. 7, 8, 12). Walker referred claimant to Dr. Camp, neurosurgeon, for evaluation.

Dr. Reimer, neurologist, examined claimant and performed a file review for the employer. (Exs. 16, 22, 23, 24). Dr. White, neurosurgeon, performed a file review for the employer. (Ex. 26).

The employer denied claimant's right shoulder condition "diagnosed as C4-5, C5-6 and C6-7 herniated discs with cord impingement, and T4-5 and T5-6 neural forminal stenosis with nerve root impingement." (Ex. 18). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Walker's opinion, the ALJ concluded that claimant's degenerative disc disease in the cervical and thoracic spine is a compensable occupational disease. On review, the employer argues that claimant failed to carry her burden of establishing a compensable occupational disease under ORS 656.802, specifically contending that Dr. Walker's opinion is insufficient to prove compensability. We agree.

To establish an occupational disease, claimant must prove that her employment conditions were the major contributing cause of her cervical and thoracic conditions. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition[1] pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

The causation issue involves complex medical questions that must be resolved with expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Uris v. Compensation Department*, 247 Or 420 (1967). In evaluating the medical evidence concerning causation, we rely on those opinions which

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[1] "'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." ORS 656.005(24).

are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Walker, osteopath, upon which claimant relies.[2]

Within three weeks after his initial treatment on July 22, 1997, Dr. Walker suspected a disc condition and referred claimant for MRI studies. These studies revealed multilevel degenerative disc disease (DDD) in the cervical and thoracic areas of claimant's spine, with disc herniations at C4-5, C5-6, C6-7 with impingement and foraminal stenosis at T4-5 and T5-6, with impingement. Walker initially opined that claimant's cervical and thoracic conditions were "work related." (Ex. 12).

Walker referred claimant to Dr. Camp, neurologist, for evaluation of claimant's complaints of neck pain with numbness in the right shoulder and arm. Camp diagnosed claimant's condition as a right C6-7 disc herniation with C7 radiculopathy, opining that the left-sided disc bulges at C4-5 and C5-6 were incongruent with claimant's right-sided symptoms. (Ex. 15). Camp did not address claimant's thoracic condition. He opined that claimant's work activities can be associated with cervical injuries with overhead work and sometimes heavy overhead lifting, but stated that he was not confident that that was the cause. (Ex. 21).

Dr. Reimer, neurologist, who examined claimant for the employer, diagnosed claimant with degenerative cervical disc disease, right C7 radiculopathy, and degenerative thoracic spondylosis. He, too, opined that the thoracic condition was unrelated to claimant's current nerve root irritation at C6-7. Reimer also opined that the major contributing cause of the radiculopathy was the DDD in claimant's neck. (Exs. 16, 22).

After reading Reimer's report, Walker agreed with his physical examination and assessment, but disagreed with his opinion on causation, noting that an aggravation of a preexisting condition (the DDD) should be compensable. (Ex. 20). From this point on, however, Walker's opinions become confusing and conflicting. First, Walker concurred with counsel for the employer that claimant's claim was for an occupational disease rather than an injury. Nevertheless, Walker also agreed that claimant had a degenerative condition that preexisted her July 1997 disability and need for treatment that combined with her work activities, and that the preexisting DDD was the major cause of her post-July 1997 condition. (Ex. 25).

Although he clarified his opinion somewhat in his deposition testimony, explaining that, in his concurrence with the employer's counsel that claimant had preexisting DDD, he had been referring to claimant's presentation as an injury, *i.e.*, that the DDD preexisted her July 1997 disc herniation (Ex. 27-13), when asked whether the DDD in claimant's neck preexisted her employment at the employer, his opinion vascillated from he didn't know (Ex. 27-9); it was doubtful (Ex. 27-10); it probably did not (*Id.*); it's possible but difficult to say (Ex. 27-12); it started early in life (Ex. 27-24); some degenerative findings would be present prior to her employment (Ex. 27-25); it's impossible to confirm that it was medically probable (Ex. 27-26); it is doubtful (*Id.*); medical probability is that there would be some present prior to her employment (*Id.*); medically possible (Ex. 27-27); not probable (*Id.*).

Then, when the employer's counsel offered the following assumptions (which Walker had the opportunity to correct) that claimant had at least some degeneration present prior to her employment and that Walker did not have sufficient information to exclude other possible contributing factors to the degenerative process, Walker was unable to say with reasonable medical probability what was the major cause of the degenerative condition. (Ex. 27-34, -35).

In contrast, when claimant's attorney questioned him about whether claimant had DDD when she began work at the employer, Walker again said it was doubtful. (Ex. 27-36). Finally, in trying to assign the percentage of causation from work, and apparently agreeing with claimant's attorney that

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[2] The ALJ gave little weight to the opinions of Dr. White and Dr. Reimer on the ground that they lacked adequate information and were not well-reasoned. Because we do not find Dr. Walker's opinions either consistent or persuasive, we need not address the persuasiveness of Drs. White and Reimer.

other possible causes had been eliminated, Walker said he would "just like to say 50 percent," but then he stated "With her job and what she's been doing, I really think that it's at least 51 percent job-related * * * * *."[3]

Because of the confusion demonstrated in Dr. Walker's opinion, including several unexplained reversals of opinion, we do not find his final opinion persuasive, even after considering the remainder of the record. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Accordingly, because Dr. Walker's opinion is the only medical opinion regarding causation which supports claimant's claim, we conclude that the ALJ's order must be reversed.

ORDER

The ALJ's August 7, 1998 order is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

[3] Dr. Walker indicated that he referred claimant to Dr. Camp to answer the causation question, because Dr. Camp was a specialist. (Ex 27-38). The only direct opinion from Dr. Camp was his statement that "[i]t is not possible within a high level of certainty, for me to be confident that [claimant's work activity] was the cause." (Ex.21)

In the Matter of the Compensation of
EDWARD J. ANDREWS, Claimant
WCB Case No. 98-05370
ORDER ON RECONSIDERATION
VavRosky, MacColl, Olson, et al, Defense Attorneys

Claimant, *pro se*, requests reconsideration of our February 8, 1999 Order on Review that affirmed an Administrative Law Judge's order that dismissed his hearing request concerning the self-insured employer's denial of his occupational disease claim for carpal tunnel syndrome, on the basis that the hearing request was untimely. Specifically, claimant contends that he did not realize that he had to appeal the employer's denial even though the employer had allowed him to reschedule his employer-arranged medical examination. Claimant also maintains that the dismissal of his request for hearing is unjust.

As set forth in our initial order, we appreciate that claimant mistakenly believed that the employer would rescind its February 9, 1998 denial and accept his claim once he attended the IME, which had been rescheduled for April 11, 1998. Nevertheless, as we explained in the order, when a claimant fails to request a hearing challenging a denial within 60 days (but does file the request within 180 days), the claimant is required to show "good cause" for the late filing. *See* ORS 656.319(1). Under the established law, however, a claimant's misunderstanding of a carrier's claim processing actions generally does not establish "good cause" in the absence of evidence that the claimant was mislead by the carrier. *See, e.g., Randall Davis*, 48 Van Natta 369 (1996); *Wayne A. Moltrum*, 47 Van Natta 955 (1995); *Roger Eli*, 47 Van Natta 1938 (1995). Nothing about the circumstances of this case convinces us to depart from the general principle established by our precedent. Consequently, in this case, claimant's mistaken belief that his claim would be accepted after the April 11, 1998 IME does not constitute "good cause" for his failure to request a hearing within 60 days of the mailing of the February 9, 1998 denial.[1]

Accordingly, we withdraw our February 8, 1999 Order on Review. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED

[1] Because claimant's hearing request was untimely, we lack jurisdiction to consider the merits of his challenges to the employer's denial of his claim.

In the Matter of the Compensation of
TINA M. VICTORIA, Claimant
WCB Case Nos. 95-08856 & 95-08855
ORDER ON REMAND
Rasmussen & Tyler, Claimant Attorneys
Reinisch, et al, Defense Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Safeco Ins. Co. v. Victoria,* 154 Or App 574 (1998). The court has reversed our prior order that had affirmed an Administrative Law Judge's (ALJ's) order that found Safeco Insurance Company responsible for claimant's occupational disease claim for a bilateral elbow epicondylitis/overuse syndrome. The court concluded that we erred by not analyzing the last injurious exposure rule of responsibility and it has remanded for reconsideration.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact and repeat them for ease of reference with some minor additions.

At the time of hearing, claimant was a 25 year-old insurance worker. She worked for Safeco Insurance Company (Safeco) as a claims clerk for nearly five years until late January 1995. From the late spring of 1994 through January 1995, claimant's primary job duty was inputting medical payments on the computer. Information was entered on the computer regarding medical payments, including the claim number, the address of the medical carrier, and why the payment was being made. This repetitious activity consumed 90 to 95 percent of her work day. In November 1994, claimant first noticed pain in both her elbows, radiating into her pinkie and ring fingers. The pain was continuous, and was worsened by typing.

On February 1, 1995, claimant began work with Wilson-Heirgood. From February through April 1995, she was in training as a workers' compensation customer service representative. During the training phase of claimant's employment, she spent a substantial amount of time observing the work of her supervisor, Ms. Jones. Claimant was instructed in substantive and procedural aspects of workers' compensation claims. She was also taught to work directly with customers. Her typing duties consisted of inputting mail which accounted for 10 to 15 percent of her day or 20 to 30 minutes. By April 1995, claimant's typing duties increased to about 25 percent of her day. Claimant's typing duties at the time of hearing accounted for nearly 40 percent of her work day.

When claimant's radiating elbow pain failed to improve following her job change, she filed an "801" form with Safeco on March 3, 1995. (Ex. 1).

On March 15, 1995, Dr. Ronan treated claimant for bilateral arm pain. (Ex. 3). Claimant's pain started in the elbows with shooting pains extending into her hands. (*Id.*) Dr. Ronan restricted claimant's work to no repetitive work with her hands and wrists, and she was given wrist splints. (Ex. 3a). By April 4, 1995, claimant's wrist complaints had increased and the splints were discontinued. (Ex. 4-2). Physical therapy was prescribed. Nerve conduction studies on May 16, 1995 were normal. (Exs. 6-3, 8).

Safeco denied responsibility for claimant's bilateral elbow pain on June 2, 1995. (Ex. 9). On June 16, 1995, SAIF, on behalf of Wilson-Heirgood, denied responsibility of claimant's overuse syndrome of the left and right elbows. (Ex. 13).

On July 13, 1995, claimant was examined by Dr. Woolpert, on behalf of SAIF. (Ex. 14). He felt that claimant's work at Safeco was the major contributing cause of her bilateral medial epicondylitis. (Ex. 14-3).

The Workers' Compensation Department issued an order pursuant to ORS 656.307 designating SAIF as the paying agent. (Ex. 18).

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[1] We granted the SAIF Corporation's request for supplemental briefing on remand, and have received briefs from Safeco and SAIF.

CONCLUSIONS OF LAW AND OPINION

At hearing, Safeco argued that responsibility should be assigned by application of the last injurious exposure rule. The ALJ found that both employments were capable of contributing to claimant's bilateral elbow epicondylitis/overuse syndrome. Claimant sought to prove actual causation based on her employment with Safeco. The ALJ found that claimant's symptoms began during her employment with Safeco and were not worsened by her employment with SAIF's insured. The ALJ concluded that claimant's work with Safeco was the major contributing cause of her treatment and/or disability and, therefore, Safeco was responsible for her condition. On review, we adopted and affirmed the ALJ's order.

On judicial review, Safeco contended that the Board erred in failing to apply the last injurious exposure rule of responsibility. Specifically, Safeco argued that the Board erred in equating "major causation" with "actual causation." Safeco contended that, unless "actual cause" was interpreted as meaning "sole cause," the purpose of the last injurious exposure rule would be thwarted.

Claimant responded that the last injurious exposure rule should be restricted to cases where it is impossible to determine which employment was the major cause of a claimant's compensable injury. The court was not persuaded by claimant's argument because it employed a principle of the last injurious exposure rule when it is used as a rule of proof. *Victoria*, 154 Or App at 577. In this case, only the last injurious exposure rule of assignment of responsibility was at issue. The court cited *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 82 (1997), explaining that

> "[p]roof that the subsequent employment independently contributed to the current disability is required before the [last injurious exposure] rule of responsibility can be invoked defensively by the targeted employer."

The court reasoned that once the last injurious exposure rule of responsibility is invoked, proof of sole causation by the previous employment, or proof of impossibility by the more recent employment, is required to avoid responsibility. *Victoria*, 154 Or App at 577. The court referred to the finding that the experts had agreed there was "contribution from the employment activities at both employers." *Id.* at 577-78. Therefore, the court reasoned that SAIF's insured was the last employer that could have caused claimant's arm condition and it concluded that was sufficient to invoke the last injurious exposure rule as a rule of responsibility. The Court of Appeals reversed our prior decision and has remanded for reconsideration. Consistent with the court's mandate, we proceed with our reconsideration.

In its supplemental brief on remand, SAIF agrees that it is initially responsible for claimant's condition under the last injurious exposure rule. SAIF contends, however, that the record establishes that claimant's employment with Safeco was the sole cause of her condition and, therefore, responsibility lies with Safeco.

Safeco responds that the "law of the case" is that both employments contributed to claimant's condition because the Court of Appeals accepted and adopted that finding. We need not address Safeco's "law of the case" argument because, even if we assume, without deciding, that we are not precluded from reviewing the record and making new findings of fact,[2] we adhere to our previous conclusion that adopted the ALJ's finding that both employments contributed to claimant's bilateral elbow epicondylitis/overuse syndrome.

Both parties agree that, by applying the last injurious exposure rule of responsibility, SAIF is assigned initial responsibility for claimant's condition. Claimant first sought treatment for her bilateral arm condition on March 15, 1995, while working for SAIF's insured and, therefore, SAIF is initially responsible. *See Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994) (if a claimant received medical treatment before experiencing time loss, the date the claimant first received treatment is the triggering date for the initial assignment of responsibility).

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[2] *See Liberty Northwest Ins. Corp. v. Verner*, 147 Or App 475, 479 (the court's holdings in "Verner I and II" did not preclude the Board on remand from reviewing the record and making new findings of fact), *rev den* 325 Or 438 (1997).

An employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case or (2) that the disease was caused solely by conditions at one or more previous employments. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). We find no such evidence in this case. Rather, the evidence establishes that both of claimant's employments contributed to her bilateral elbow epicondylitis/overuse syndrome.

Claimant worked at Safeco as a claims clerk for nearly five years until late January 1995. On February 1, 1995, she began working for SAIF's insured. When Dr. Ronan examined claimant on March 15, 1995, he reported that she had switched jobs on February 1, 1995, and her discomfort "has not changed since she changed her jobs." (Ex. 3-2). On March 24, 1995, Dr. Layne reported that claimant had changed jobs where she did much less typing, but she "still notes pain of a similar nature when she is typing." (Ex. 4-1). Dr. Wuest indicated on May 3, 1995 that claimant's pain in her elbows and hands persisted in her new job. (Ex. 6-1). He commented that claimant did not "note any marked improvement on 2-1-95 when she changed jobs." (*Id.*)

In June 1995, Dr. Layne reported that claimant's symptoms began while working at Safeco and she had similar symptoms while working for SAIF's insured. (Exs. 10, 11). Dr. Layne felt that claimant's symptoms were related to a specific activity, *i.e.*, typing and/or data entry, and were not necessarily related to where she worked. (*Id.*)

Dr. Woolpert examined claimant on behalf of SAIF and reported that the onset of claimant's symptoms occurred while working for Safeco and her problem did not subside when she switched jobs. (Ex. 14-3). Drs. Wuest and Layne concurred with Dr. Wuest's report. (Exs. 16, 17). In a later report, Dr. Woolpert agreed that claimant's bilateral arm complaints were caused in some part by her work at SAIF's insured. (Ex. 15).

On remand, we adhere to our previous conclusion that adopted the ALJ's finding that both employments contributed to claimant's bilateral elbow epicondylitis/overuse syndrome. In particular, the medical evidence establishes that claimant's employment with SAIF's insured contributed to her condition. We are not persuaded that claimant's condition was caused solely by her employment with Safeco. Furthermore, we find no evidence that it was impossible for conditions at SAIF's insured to have caused claimant's condition. Consequently, responsibility for claimant's bilateral arm condition remains with SAIF.

Accordingly, on reconsideration of our order dated January 8, 1997, we reverse the ALJ's April 26, 1996 order. Safeco's denial is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. SAIF is responsible for the payment of the $2,000 attorney fee award granted by the ALJ.

IT IS SO ORDERED.

March 8, 1999 Cite as 51 Van Natta 380 (1999)

In the Matter of the Compensation of
JORGE GARFIAS-LARA, Claimant
WCB Case Nos. 97-02664 & 96-11236
ORDER ON RECONSIDERATION
Willner & Associates, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our February 9, 1999 Order on Review, in which we affirmed the Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's injury claim for low back disc herniations/bulges. The insurer argues that we did not properly evaluate the evidence under the material contributing cause standard we determined was applicable, and that, in any event, we should have found a "combined condition" under ORS 656.005(7)(a)(B) and applied a major contributing cause standard. Specifically, the insurer requests that we address whether disc conditions at L4-5 and L5-S1 preexisted the March 9, 1996 injury and whether we would find a "combined condition" if "magic words" are not used.

On further consideration, we continue to conclude that claimant sustained his burden of proving that his compensable injury is a material contributing cause of his need for treatment and/or disability. Moreover, we do not find it necessary to address the insurer's specific inquiries. That is, we need not decide whether we can infer a "combined condition" from medical evidence when, as noted in our original order, a physician (Dr. Rosenbaum) specifically stated that claimant's preexisting degenerative disc disease did not combine with the compensable injury. (Ex. 35-5). As to the question of preexisting conditions, that matter is moot in light of Dr. Rosenbaum's opinion.

Accordingly, we withdraw our February 9, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our February 9, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 8, 1999 Cite as 51 Van Natta 381 (1999)

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Case Nos. 94-10782, 94-10774, 94-10781, 94-10773 & 94-05124
THIRD 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

Douglas County Forest Products/Liberty Northwest (DCFP/Liberty Northwest) requests reconsideration of our December 28, 1998 Second Order on Remand, asking that we reconsider the responsibility ruling in our first Order on Remand. In our first Order on Remand, we set aside DCFP/Liberty Northwest's denial of claimant's occupational disease claim for bilateral hearing loss. *Jon O. Norstadt*, 50 Van Natta 1789 (1998). In our second Order on Remand, we assessed penalties for unreasonable resistance to compensation and awarded claimant's counsel an assessed attorney fee. *Jon O. Norstadt*, 50 Van Natta 2416 (1998). On reconsideration, DCFP/Liberty Northwest contends that Murphy Plywood/Liberty Northwest is responsible for claimant's condition. Having received responses from claimant and Murphy Plywood, we proceed with our reconsideration.

DCFP/Liberty Northwest argues that the employment exposures during which claimant suffered the "only discernible worsening" of his hearing loss should be treated as establishing the claim and we should determine a "new onset of disability" for the "fictitious compensable worsening." According to DCFP/Liberty Northwest, Dr. Owens' reports from October 1993 (Exs. 8, 9, 10) establish that claimant was informed at that time that his hearing loss had an industrial cause. DCFP/Liberty Northwest argues that, among the three remaining employment exposures, claimant's work at Murphy Plywood most immediately preceded this new "onset of disability" and, therefore, responsibility must be assigned to Murphy Plywood. DCFP/Liberty Northwest argues that responsibility must remain with Murphy Plywood because neither claimant nor Murphy Plywood can prove any actual contribution from the remaining parties.

We are not persuaded by DCFP/Liberty Northwest's argument that we should assign a new "onset of disability" to this case. In our Order on Review, *Jon O. Norstadt*, 48 Van Natta 253 (1996), we concluded that the onset of disability occurred in October 1986, not October 1993, as DCFP/Liberty Northwest asserts.[1] We explained:

> "If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial

[1] In our May 30, 1996 Order on Reconsideration, we did not modify this particular holding. *Jon O. Norstadt*, 48 Van Natta 1103 (1996).

responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. *SAIF v. Kelly*, 130 Or App 185, 188 (1994).

"Claimant first sought treatment for his compensable hearing loss on October 13, 1986, when he was examined by Dr. Scott. (Ex. 1). *See Timm v. Maley, supra; SAIF v. Kelly, supra.* Dr. Scott reported that claimant was then working at Douglas County Forest Products. (Exs. 1, A). In October 1986, Douglas County Forest Products was insured by Lumbermen's Underwriting Alliance. Therefore, we would ordinarily assign presumptive responsibility for claimant's compensable condition to Douglas County Forest Products/ Lumbermen's Underwriting Alliance. We note that, although the disclaimer from Parkway Ford/Liberty notified claimant of a potential claim against Douglas County Forest Products/ Lumbermen's Underwriting Alliance, (Ex. 51), claimant apparently did not file a claim against that carrier and it was not a party to the hearing." 48 Van Natta at 258 (footnote omitted).

The Court of Appeals held that substantial evidence supported the findings that claimant's hearing loss was work related and that, under the last injurious exposure rule, presumptive responsibility for claimant's hearing loss should rest with Douglas County Forest Products/ Lumbermen's Underwriting Alliance, because claimant first sought treatment for the condition while employed there in 1986. *Norstadt v. Murphy Plywood*, 148 Or App 484, 487, *modified* 150 Or App 245 (1997).

Even if we assume, without deciding, that we may make new findings of fact in this case,[2] we are not persuaded by DCFP/Liberty Northwest's argument. The Court of Appeals held that responsibility should be assigned among Murphy Plywood, DCFP/Liberty Northwest and Parkway Ford, each of which is precluded from asserting responsibility as a defense. *Norstadt*, 148 Or App at 495. On reconsideration, we adhere to our opinion in our first Order on Remand that claimant's most proximate employment exposure to his 1986 "disability date" occurred while he was working for DCFP. *Norstadt*, 50 Van Natta at 1789. Under these circumstances, we hold that DCFP/Liberty Northwest is responsible for the processing of claimant's hearing loss claim.

Claimant's attorney is entitled to an assessed fee for services on reconsideration. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration is $250, payable by Douglas County Forest Products/Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the 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.

On reconsideration, as supplemented herein, we adhere to and republish our December 28, 1998 Second Order on Remand order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] *See Liberty Northwest Ins. Corp. v. Verner*, 147 Or App 475, 479 (the court's holdings in "Verner I and II" did not preclude the Board on remand from reviewing the record and making new findings of fact), *rev den* 325 Or 438 (1997).

In the Matter of the Compensation of
FLORIAN D. STAN, Claimant
WCB Case No. 98-01004
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

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

FINDINGS OF FACT

Claimant sustained a left foot injury on August 20, 1997, when a co-worker's fork lift truck ran over his foot. At the time of injury, claimant was returning to his work station on the employer's premises after a paid break. The accident occurred when the co-worker drove forward as claimant was reaching for a control device on his co-worker's lift truck. The record establishes that reaching for the control devices of another lift truck was prohibited activity. (Tr. 103). Claimant requested a hearing after the employer denied that the injury was compensable on the ground that it occurred as a result of prohibited activities.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial, finding that claimant's injury arose out of and in the course of employment. The ALJ reasoned that the alleged prohibited act (claimant's attempting to reach a control handle on another lift truck) was not sufficient to preclude the compensability of his injury. The employer argues on review that claimant's alleged prohibited conduct removed claimant from the course and scope of employment when the injury occurred.[1] We agree.

For an injury to be compensable under workers' compensation law, it must arise out of and occur in the course of employment. ORS 656.005(7)(a). Compensability of an injury depends on whether, considering all relevant factors, the activity causing the injury was sufficiently connected to work. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994); *Rogers v. SAIF*, 289 Or 633, 642 (1980). In *First Interstate Bank of Oregon v. Clark*, 133 Or App 712, 717 (1995), the court held that the "totality of the circumstances" must be considered in determining if the claimant has shown a sufficient work connection.[2]

Here, while it is clear that claimant was aware that manipulating the controls of another lift truck was prohibited (Tr. 41), that fact alone would not determine whether claimant's injury was sufficiently work-connected to be compensable. *Andrews*, 323 Or at 165. However, considering the totality of the circumstances, we find that the evidence does not establish a sufficient work connection.

No party disputes that claimant was in the course of employment when injured. He was on the employer's premises and returning to work from a paid break when the injury occurred. The instrumentality of the injury (fork lift) was a work tool. Moreover, the employer concedes that being run over by a fork lift was a foreseeable risk of claimant's employment. As the employer notes, the sole factor that militates against compensability is the fact that claimant was engaged in prohibited conduct when he was injured.

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[1] The employer asserts that claimant was engaged in "horseplay" when he reached for the controls of the co-worker's lift truck. Because of claimant's language difficulties, the record is not clear why claimant reached for the controls of the lift truck, but the testimony of the lift truck operator and another co-worker indicated that claimant made numerous attempts to reach the controls of the lift truck. (Trs. 61, 81). We agree with the employer that claimant was most likely engaged in "horseplay" when he was injured. This fact does not necessarily preclude a finding of compensability. *See Kammerer v. United Parcel Service*, 136 Or App 200, 204 (1995) (discussing principles underlying compensation for certain injuries received as result of horseplay).

[2] In *Andrews v. Tektronix, Inc.*, 323 Or 154, 160, 164 (1996), the Court reiterated that "fault is irrelevant in determining a worker's entitlement to compensation," and rejected a general rule that would deny compensation for injuries sustained as a result of a worker's failure to follow an employer's instructions. The Court further stated that a worker's failure to follow the employer's instructions is only one of many factors to consider in the overall calculation of work-connectedness. 323 Or at 165. A determination that a worker has disobeyed the employer's instruction is not a substitute for the analysis of work-connectedness. *Id.*

In *Andrews*, the Court explained the role prohibited conduct plays in the overall determination of "work-connectedness."

> "We are not prepared to say that the simple fact of disobedience to an employer's orders is of such overarching significance that it, alone, can render an ensuing injury noncompensable. Even when an order purports to set the boundaries of the claimant's ultimate work, a worker's disobedience is not necessarily determinative.
>
> "That is not to say that an employer's delineation of what does and does not constitute an employee's job is inconsequential. The Workers' Compensation Act does not purport to apportion liability for a worker's injuries on the basis of a mere nominal relationship between the worker and employer. But the facts that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the overall calculation of work-connectedness. Among the additional factors are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like. Moreover, when a worker's failure to follow a work-defining instruction is taken into consideration, the manner in which the instruction was conveyed, and the worker's consequent perception of the instruction's purpose and scope, also must be considered." 323 Or at 165.

In this case, claimant clearly disobeyed the employer's prohibition against tampering with the controls of another forklift. Moreover, we agree with the employer that, unlike *Andrews*, this case involved more than a prohibited method of accomplishing claimant's job. Claimant here had not resumed his work when he made multiple attempts to reach the controls a coworker's fork lift truck. Claimant was not involved in any work activity when he was injured. Further, no degree of judgment or latitude was involved in claimant's actions. The employer clearly prohibited interfering with the lift controls of another worker's fork lift. As the employer notes, the risk of injury to claimant was great, while there was no benefit to the employer in reaching multiple times for the controls of the fork lift.[3] Finally, we find that the prohibition against manipulating the controls of another worker's fork lift was made clear to all employees. Indeed, the witnesses unanimously agreed that this conduct was strictly forbidden and would, and did, result in disciplinary action. (Trs. 41, 76, 86, 95, 103, 104; Ex. 10A).

Accordingly, based on our *de novo* review of the record, and applying the *Andrews* criteria, we conclude that claimant failed to prove a sufficient work connection between his injury and his employment. Therefore, we find that claimant's injury did not arise out of and in the course of employment. Thus, we reverse.

ORDER

The ALJ's order dated July 10, 1998 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[3] In reaching this conclusion, we reject any suggestion in claimant's testimony that his actions were motivated by safety concerns. (Tr. 23-25). Instead, we conclude that no legitimate safety concern justified claimant's multiple attempts to interfere with the operation of another fork lift.

Board Member Biehl dissenting.

The majority finds that claimant failed to prove a sufficient work connection between his left foot injury and employment and, therefore, that his injury did not arise out of and in the course of his employment. Because I would reach the opposite conclusion, I respectfully dissent.

An injury is compensable if it "aris[es] out of and in the course of employment." ORS 656.005(7)(a). The "arising out of [employment]" prong concerns the causal connection between the injury and the employment. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). The "in the course of employment" prong concerns the time, place and circumstances of the injury. *Id.* The two prongs constitute a unitary work-connection test, that is, "whether the relationship between the injury and the employment is sufficient that the injury should be compensable." *Id.* Both the "arising out of" and the

"in the course of" prongs must be satisfied to some degree. *Krushwitz v. McDonald's Restaurants*, 323 Or 520 (1996). However, deficiencies in the strength of one factor may be made up by the strength of the other. *Henderson v. S.D. Deacon Corp.*, 127 Or App 333, 335 (1994).

As the majority notes, no party disputes that claimant was in the course of employment when injured. He was on the employer's premises and returning to work from a paid break when the injury occurred. With regard to the "arising out of " element, the instrumentality of the injury (fork lift) was a work tool. In addition, the employer concedes that being run over by a fork lift was a foreseeable risk of claimant's employment. Thus, there are at least minimal factors that satisfy that element of the work connection test. The sole factor that works against compensability is the fact that claimant was engaged in prohibited conduct when he was injured.

As previously noted, however, the work-connection test may be satisfied if the factors supporting one prong of the statutory test in ORS 656.005(7)(a) are minimal, while the factors supporting the other prong are many. *Krushwitz v. McDonald's Restaurants*, 323 Or at 531 (citing *Phil A. Livesley Co. v. Russ*, 296 Or 25 (1983)). That is precisely the situation that exists in this case. Here, the factors supporting the "course of employment" prong are many, even though those supporting the "arising out of" prong are arguably less substantial (but at least minimal). Under these circumstances, I would find claimant's injury sufficiently work-related under the two-prong work-connection test.

Accordingly, I would affirm the ALJ's determination that claimant's injury is compensable. Because the majority decides otherwise, I dissent.

In the Matter of the Compensation of
BETTY J. SKINNER-LOVEN, Claimant
WCB Case No. 97-10137
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's denial of claimant's injury or occupational disease claim for a cervical condition. On review, the issue is compensability.

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

We agree with the ALJ that the medical evidence does not support the claim: Although there is evidence that claimant's work caused her symptoms, there is no evidence that it caused her cervical condition.[1]

We also acknowledge claimant's contention that the claim should be compensable under ORS 656.005(7)(a)(B), based on *SAIF v. Nehl*, 140 Or App 349, *recon* 149 Or App 309 (1997), *rev den* 326 Or 329 (1998). However, because we agree with the ALJ that this case is properly analyzed as an occupational disease, neither ORS 656.005(7)(a)(B) nor *Nehl* apply. *See Willard A. Hirsch*, 49 Van Natta 1311, n.1 (1997) (*Nehl* does not apply to occupational disease claim).

ORDER

The ALJ's order dated October 5, 1998 is affirmed.

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[1] We do not find that claimant had a cervical condition that preexisted her employment exposure under ORS 656.802(2)(b). *See New Portland Meadows v. Dieringer*, 153 Or App 383, 387 (1998). Nonetheless, we agree with the ALJ that claimant has not carried her burden under ORS 656.802(2)(a) because the medical evidence does not show that claimant's work was the major contributing cause of her condition.

In the Matter of the Compensation of
GLORIA A. STURTEVANT, Claimant
WCB Case No. 98-00760
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Stoel Rives LLP, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

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

As a preliminary matter, we reject the employer's contention that the ALJ erred in addressing certain evidence, specifically statistical studies about the occurrence of CTS in various populations. (*See* Exs. 46-57). The employer does not object to *admission* of the evidence. Therefore, the employer's arguments go to the weight of the evidence, not admissibility. There is no actual controversy about the statistical evidence beyond its persuasiveness.[2] *See Gail J. Keller*, 50 Van Natta 2144 (1998) ("[I]nsofar as the doctors' opinions are allegedly inadequately supported by scientific evidence, that evaluation goes to the weight accorded the evidence, not to its admissibility.").

On the merits, the ALJ opined that the case "turns primarily on the validity of the appeal to the medical literature." Opinion and Order, p. 7. We do not agree that the case turns primarily on the "literature." We do, however, agree with the ALJ's ultimate conclusion that the claim is compensable, based on the persuasive medical evidence.

Drs. Merrick, Klos, Herring, Wuest, and Nathan provide the primary medical evidence addressing the cause of claimant's CTS. Drs. Merrick,[3] Klos, Herring, Wuest agree that claimant's 17 years of repetitive work activities involving her upper extremities were the major contributing cause of her CTS. (*See* Exs. 25, 34, 36, 37, 39).

Dr. Nathan opined that claimant "fits the profile of individuals who develop carpal tunnel syndrome from intrinsic (internal/personal) causes rather than from any identifiable external traumatic source." (Ex. 7-5). Based on claimant's sex, age, obesity, and off work inactivity, in light of medical literature finding CTS more prevalent among persons with those characteristics, Dr. Nathan concluded that the characteristics were the major contributing cause of her CTS. (*Id*). Dr. Nathan also opined that claimant's hand usage at work did not involve activities that would cause CTS. (*See* Ex. 35). We do not find Dr. Nathan's opinion persuasive for two important reasons.

First, the statistical incidence of CTS generally is not evidence of causation in this case. *See Shannon L. Mathews*, 48 Van Natta 1839, 1840 (1996), *aff'd mem* 148 Or App 635 (1997); *Allen B. White, Sr.*, 46 Van Natta 1779, 1780 (1995) ("No matter how rarely a condition might occur in the general population, such a statistical improbability is insufficient to defeat a claim where the medical evidence establishes that the condition did occur in a claimant's particular case.").

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[1] But we do not adopt the ALJ's "Findings of Ultimate Fact."

[2] The employer argues that the ALJ should have evaluated the evidence interpreting statistical studies about CTS under a "good science/bad science" standard before admitting it. But the employer relies on cases evaluating *admissibility* of expert evidence and these cases are not controlling because admissibility is not at issue here. *See Jimmie D. Jordan*, 43 Van Natta 1161 (1991) (declining to issue advisory opinions, absent a controversy).

[3] Dr. Merrick initially opined that claimant's CTS is probably work-related. (Ex. 3). Then he checked a box indicating concurrence with Dr. Nathan's opinion to the contrary. (Ex. 15). Later, Dr. Merrick restated his original opinion relating claimant's CTS to her work. (Ex. 39). Dr. Merrick's ultimate opinion is not persuasive standing alone, because the doctor offered no explanation for prior variations.

We also find Dr. Nathan's reasoning unpersuasive because it is based in part on inaccurate assumptions that claimant's work activities were not repetitive or otherwise injurious. Dr. Nathan does not believe that work activities are ever a significant cause of CTS. (*See* Tr. 108-09, 114). But we agree with the ALJ that a preponderance of the persuasive evidence in this case indicates work activities *do* contribute significantly to claimant's CTS. Because we do not accept Dr. Nathan's underlying premise, we also discount his reasoning to the extent it is based on that premise.

Claimant worked for the employer as a feeder and operator of a veneer laminating press. She usually took half-hour turns with a partner feeding, then operating, the press. Feeding the press required upper extremity use to move 3,000 to 5,000 sheets of veneer per work shift. Nonetheless, Dr. Nathan stated that claimant's work was not repetitive. (Tr. 124-25, 140). We do not see how claimant could have performed a manual operation several thousand times in a work shift without it being repetitive. Consequently, we find Dr. Nathan's opinion unpersuasive in part because it is based on an inaccurate belief that claimant's work activities were not repetitive. (*See* Ex. 40A-5).

Dr. Nathan further opined that claimant's work activities were not injurious because they did not involve flexion, dorsiflexion, or extension of the wrist. (Tr. 118; *see* Ex. 41-8). He also discounted wrist rotation as an injurious activity, stating that wrist pronation and supination have not been "described" or "demonstrated" as causing CTS. (Tr. 127-28, 140). But there is evidence, in this record, describing claimant's work activities, which include twisting and turning her wrists, as causative. (*See* Exs. 25, 37, 39; *see also* Exs. 34, 36, 40A-5).

Claimant used a quarter turn of her wrist to flip each sheet of veneer and shake off debris before feeding sheets into the press one at a time. About half of each sheet manipulation task involved wrist rotation. Twenty to thirty percent of the time, claimant flipped the sheet all the way over so that it would be flat enough to feed. (Tr. 14, 19-23, 32). Claimant fed sheets into the press with the back of her hand, the palm of the hand between the thumb and first finger, or with a pinching motion. (Tr. 20). Each feeding took between 5 and 10 seconds.

When claimant took her turn operating the press (rather than feeding it), about half of the work involved hand and arm use. (Tr. 30). The above described activities, particularly press feeding, clearly involved changing hand positions and moving her wrists and upper extremities with every sheet of veneer.

Except for Dr. Nathan's opinion, the medical record accurately describes claimant's work activities as involving repetitive use of her upper extremities. The doctors supporting the claim considered and evaluated noncompensable contributing causes (including claimant's obesity) and *potential* contributing causes (including diabetes, alcoholism, muskuloskeletal abnormalities, hypothyroidism, and off-work activities). They discounted the former (considering claimant's work activities and her clinical course) and ruled out the latter as noncontributory. (*See* Exs. 25, 36-1-2, 37-1-3, -6, 39). Dr. Klos also found claimant's clinical course consistent with a work relationship, specifically noting that claimant's CTS had improved with conservative therapy and weight loss, but increased again when her workload increased. (Exs. 25, 36). We find the opinions of Drs. Klos, Herring and Wuest persuasive because they are well-reasoned and consistent with claimant's history. Accordingly, based on these opinions, we agree with the ALJ that claimant has carried her burden.

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 September 16, 1998 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
LONNY L. WARD, Claimant
WCB Case No. 98-05117
ORDER ON REVIEW
Francis & Martin, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the insurer's denial of his occupational disease claim for a bilateral shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On March 4, 1998, claimant, a mill worker, filed an occupational disease claim, alleging that his work activities (consistent movement of the arms and shoulders while feeding a glue press) caused a right shoulder strain. Claimant sought treatment on March 6, 1998 from Dr. Jacobson, who reported that claimant had developed bilateral shoulder pain over the last couple of months. Dr. Jacobson diagnosed bilateral rotator cuff tendonitis, right worse than left. (Ex. 2).

On May 19, 1998, an examining physician, Dr. Gripekoven, reported that he did not have a physiological explanation for claimant's bilateral shoulder pain, but that the major contributing cause of claimant's need for treatment appeared to be a degenerative partial rotator cuff tear in the right shoulder. (Ex. 9-6). The insurer then denied claimant's shoulder condition on June 3, 1998, alleging that it did not arise out of and in the course of employment. (Ex. 11-1). Claimant requested a hearing.

The ALJ upheld the insurer's denial, finding that claimant had failed to sustain his burden of proving that work conditions were the major contributing cause of his shoulder condition. In making this finding, the ALJ found the opinions of Dr. Gripekoven and another examining physician, Dr. Farris, more persuasive than Dr. Jacobson's. The ALJ noted that, in concluding that claimant's work activity was not the type that could have caused claimant's shoulder condition, both Dr. Gripekoven and Dr. Farris had viewed a videotape of claimant's work activity (whereas Dr. Jacobson had not). In addition, the ALJ faulted Dr. Jacobson for not addressing the history that claimant's symptoms continued and even worsened after he began performing modified work and limiting the time he spent feeding the glue press.

On review, claimant contends that Dr. Jacobson's opinion is well-reasoned and more persuasive than the opinions of Drs. Gripekoven and Farris. For the following reasons, we agree.

The parties agree, and we find, that, given the gradual onset of symptoms, this is an occupational disease claim. *See James v. SAIF*, 290 Or 343, 348 (1981); *Jeff R. Elizalde*, 50 Van Natta 2229 (1998). Because claimant's occupational disease claim is not based on the worsening 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 his work activities are the major contributing cause of his bilateral shoulder condition.

Claimant relies on Dr. Jacobson's opinion to establish compensability of the shoulder condition. In evaluating the medical evidence concerning causation, we rely on opinions that are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). We generally give greater weight to the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Based on the following discussion, we do not find persuasive reasons to depart from our customary deference to the attending physician.

Dr. Jacobson initially opined on June 10, 1998 that claimant's 12 years of operating machinery (which, according to Dr. Jacobson, required fairly constant abducted positioning of the upper extremity)

was a "classic job description" for creating an impingement process in claimant's shoulders. (Ex. 13-1). In a later report, Dr. Jacobson explained he was quite familiar with the machinery that claimant operated and had the opportunity to view videotape of individuals who had performed claimant's job. Dr. Jacobson reiterated his opinion that claimant's job put his upper extremity in a position which predisposed him to chronic wear and tear of the rotator cuff tendon. (Ex. 16-2). Finally, Dr. Jacobson disagreed with the opinions of Drs. Gripekoven and Farris and emphasized that claimant's job required chronic maintenance of the upper extremity in abduction and that, even if the abduction was less than 45 degrees, it could result in rotator cuff fatigue and an impingement process. (Ex. 19).

We conclude that Dr. Jacobson's opinion is well-reasoned and based on an accurate history. Therefore, we find it persuasive. Moreover, we do not agree with the ALJ's reasons for discounting it. Although Dr. Jacobson did not view the videotape shown to Dr. Farris and Dr. Gripekoven, Dr. Jacobson represented that he was familiar with claimant's job duties and had seen similar videotapes in the past. (Ex. 16-2). In addition, Dr. Jacobson did address claimant's failure to improve, noting that subacromial injections had failed to improve claimant's condition because of a "partial thickness cuff pathology." (Ex. 13-1).

The insurer argues, however, that claimant engages in strenuous off-the-job activity (such as bow hunting, auto repair, and bowling) "some or all of which actually could have caused or contributed to his condition." We disagree with the insurer's assertion that these activities are a causal factor in claimant's shoulder problems. Claimant testified that his shoulder did not hurt when he drew his bow. (Tr. 32). Claimant also testified that, when he "pulled" an engine, it was not done by hand, but rather by holding a chain to the motor and using a hoist. (Trs. 29, 30). Finally, claimant testified his shoulders did not bother him when he bowled. (Tr. 26). Based on our review of claimant's credible testimony, we find that off-the-job activities are not a significant factor in claimant's pain complaints. Also, there is no medical evidence that these activities contributed to claimant's shoulder condition.

Accordingly, we conclude that, based on Dr. Jacobson's opinion, claimant has sustained his burden of proving a compensable occupational disease claim.[1] Thus, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 30, 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 at hearing and on review, claimant's attorney is awarded an assessed fee of $3,500, to be paid by the insurer.

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[1] We find Dr. Jacobson's opinion to be more persuasive than either Dr. Gripkoven's or Dr. Farris'. Dr. Gripekoven opined that claimant had a degenerative tear of the right rotator cuff compatible with "long-term attrition of the shoulder." (Ex. 9-5). Dr. Gripekoven does not explain, however, what caused the "attrition." Dr. Farris opined that, if claimant had a rotator cuff tear, it would be due to the activities of daily living, a natural degenerative process and claimant's work activities. (Ex. 14-8). As claimant notes, Dr. Farris does not explain what activities of daily living were causative, nor does he explain how a degenerative process occurred in someone of claimant's age (31).

In the Matter of the Compensation of
LESLIE D. CUSTER, Claimant
WCB Case No. 98-05791
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that assessed a $3,600 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issue is attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of her injury claim. Following the hearing, the ALJ found that claimant had established the compensability of her knee injury, and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $3,600 after considering the factors set forth in OAR 438-015-00010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that his explanation for the $3,600 fee award is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood*, 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood*, 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors he considered in determining the fee. The ALJ explained that, in awarding the $3,600 fee, he particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated.[1] This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale.[2]

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

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[1] Although the parties did not present argument at hearing concerning the application of factors in OAR 436-015-0010(4), claimant did request a specific fee two days after the hearing. Claimant's counsel requested a fee of $3,600, citing the time he devoted to the case (18 hours) and his 21 years experience as a workers' compensation attorney. SAIF did not object to this submission, nor does SAIF contend on review that the assessed attorney fee was excessive.

[2] Because SAIF challenged only the attorney fee award on review and 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 review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1998).

In the Matter of the Compensation of
BRUCE J. MINKOFF, Claimant
WCB Case No. 98-04880
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of claimant injury or occupational disease claim for a low back herniated disc condition. On review, the issue is compensability.

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

We agree with the ALJ that this claim is properly analyzed as an occupational disease because the onset was gradual, not sudden and unexpected. We also agree that claimant probably had a preexisting low back condition (at least a predisposition (*see* Ex. 23-2)) that contributed to his recent disc condition.[1] We further agree that Dr. Belza's opinion supporting the claim is unpersuasive.

Dr. Belza felt that claimant's L5-S1 herniated disc "was more likely due to work activities within the last year, rather than due to a long-standing degenerative process." (Ex. 23-1). But the only work activity Dr. Belza mentioned was moving propane tanks. He did not discuss the fact that claimant's low back symptoms began *before* the alleged propane tank-lifting incident and his radiculopathy symptoms only began *after* chiropractic manipulations. (*See* Exs. 4-1, 19). And Dr. Belza was apparently unaware that claimant told his chiropractor that he had an "acute exacerbation * * * while he was getting into his truck." (Ex. 20). In light of these facts, and even if claimant's herniation was "recent," we cannot say that Dr. Belza's opinion relating the herniation to lifting at work was based on a reliable, complete history. Because we find no persuasive medical evidence relating claimant's condition to the claimed work incident (or work activities generally), we agree with the ALJ that claimant has not carried his burden of proof.

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

[1] We note that no medical evidence relates claimant's degenerative "condition/predisposition" to his work activities.

In the Matter of the Compensation of
BARBARA PORTER, Claimant
WCB Case No. C9-00019
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Cathcart & Borden, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Bock and Moller.

On January 12, 1999, 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 February 26, 1999, we received the claimant's addendum to the CDA. We treat the 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 January 12, 1999. We received the addendum to the CDA on February 26, 1999, 45 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).[1]

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.

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[1] The addendum seeks to correct the claim number recited on the CDA, as well as the date of injury (January *16*, 1998, rather than January *15*, 1998). As previously noted, we are without authority to reconsider our approval order. Nonetheless, if the claim number and injury date set forth in the parties' CDA are inaccurate, the motion apparently confirms that the parties are aware of these clerical errors.

In the Matter of the Compensation of
BRIAN L. SCHMITT, Claimant
WCB Case No. 98-02232
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that determined that claimant's right wrist claim was prematurely closed. On review, the issues are premature closure, and (potentially) extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right wrist on January 22, 1991. (Ex. 3). The insurer accepted a disabling right wrist strain. (Ex. 17). On July 3, 1991, Dr. Appleby recommended an excisional arthroplasty of the distal ulna with tendon interposition. (Ex. 33). The insurer issued a partial denial of claimant's current right wrist condition on September 27, 1991, asserting that his condition and need for treatment were related to a preexisting condition. (Ex. 39). Three days later, the insurer issued a Notice of Closure. (Ex. 40). A December 31, 1991 Order on Reconsideration affirmed the Notice of Closure. (Ex. 44).

Claimant requested a hearing on the insurer's partial denial. (Ex. 47). Subsequently, an ALJ set aside the insurer's denial and remanded the claim for further processing. (*Id.*)

Claimant also requested a hearing on the December 31, 1991 Order on Reconsideration. (Ex. 55). On June 13, 1995, another ALJ concluded that, based on Dr. Appleby's opinion, there was a reasonable expectation of further material improvement of claimant's right wrist condition at the time of closure in September 1991 and, therefore, the claim was prematurely closed. (Ex. 55-7). On review, the Board affirmed the ALJ's order. *Brian L. Schmitt*, 48 Van Natta 295, *on recon* 48 Van Natta 460 (1996); (ex. 65-7).

In the meantime, Providence Vantage MCO wrote to Dr. Appleby on June 19, 1995, stating that it had determined that the proposed right distal ulnar hemiarthroplasty with tendon interposition was not medically necessary and the surgery was not likely to decrease pain or improve function. (Ex. 56). The request for that surgical procedure was not approved. (Ex. 56). The notice indicated Dr. Appleby had 30 days to file an appeal. (*Id.*) Dr. Appleby did not file an appeal. (Ex. 67-1).

On March 13, 1996, the insurer issued a Notice of Closure. (Ex. 60). The Notice of Closure was amended on March 29, 1996. (Ex. 61). Claimant requested reconsideration. (Ex. 62). An Order on Reconsideration dated June 4, 1996 rescinded the Notices of Closure and determined that the claim should remain in open status. (Ex. 66). The insurer requested reconsideration, asking the Department to take notice of the fact that Dr. Appleby's surgical request had been denied by the MCO and that there had been no appeal. (Ex. 67). The Department declined to reconsider the Order on Reconsideration. (Ex. 68).

The insurer requested a hearing concerning the June 4, 1996 Order on Reconsideration. On March 13, 1997, an ALJ determined that the MCO letter had been "submitted at the reconsideration" and was part of the reconsideration record. (Ex. 69-2). The ALJ concluded that, based on the MCO's final decision that the proposed surgery was not necessary, no further material improvement would reasonably be expected from medical treatment. (Ex. 69-5). The ALJ reinstated the March 1996 Notices of Closure. (Ex. 69-6).

On September 26, 1997, the Board reversed the ALJ's order. *Brian L. Schmitt*, 49 Van Natta 1583 (1997); (ex. 70). The Board concluded that the June 19, 1995 MCO document was not part of the reconsideration record and was not admissible at the hearing on premature claim closure. *Id.* at 1585. Regarding the issue of premature claim closure, the Board found that there had been no change in claimant's condition since 1991. *Id.* at 1586. In light of the Board's previous finding that the recommended surgery would be expected to materially improve claimant's right wrist condition, the Board again concluded that claimant was not medically stationary. *Id.*

On November 10, 1997, the insurer again closed the claim by Notice of Closure, awarding 14 percent scheduled permanent disability for loss of use or function of his right arm. (Ex. 71). Claimant requested reconsideration. (Ex. 72). A medical arbiter examination was performed on February 14, 1998. (Ex. 74). A March 12, 1998 Order on Reconsideration found that the latest closure was not premature. (Ex. 75). In addition, the Order on Reconsideration determined that claimant was not entitled to any permanent disability. (*Id.*) Claimant requested a hearing concerning the March 12, 1998 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ concluded that the insurer was precluded from litigating the premature closure issue because the Board had previously addressed that issue in September 1997. The insurer argues that the ALJ confused issue preclusion with procedural claim processing issues. The insurer asserts that claim closure may occur more than once during a claim. According to the insurer, claimant is medically stationary and the claim should be closed.

Claimant argues that, because the Board found in September 1997 that he was not stationary as of May 1, 1995, that issue has been litigated to final judgment and the Board's decision is deemed conclusive in any later action between the parties since the determination was essential to the judgment. We disagree with claimant's characterization of our September 1997 holding and, consequently, the effect of that holding on this case.

Issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139 (1990) (quoting *North Clackamas School Dist. v. White*, 305 Or 48, 53, *modified* 305 Or 468 (1988)). In *Washington Cty. Police Officers v. Washington Cty.*, 321 Or 430, 435 (1995), the Supreme Court explained that a decision in a prior proceeding may preclude relitigation of the issue in another proceeding if five requirements are met: (1) The issue in the two proceedings is identical; (2) the issue was actually litigated and was essential to a final decision on the merits in the prior proceeding; (3) the party sought to be precluded has had a full and fair opportunity to be heard on that issue; (4) the party sought to be precluded was a party or was in privity with a party to the prior proceeding; and (5) the prior proceeding was the type of proceeding to which this court will give preclusive effect.

Here, the issues in the two proceedings are *not* identical. The issue before the Board in the September 26, 1997 case was whether claimant's wrist condition was medically stationary at the time the claim was closed in March 1996. As expressed by the ALJ, "[t]he sole issue [was] whether claimant's right wrist condition was medically stationary when the claim was closed on March 13, 1996. (Ex. 69-4; *see also* ex. 70-4). In contrast, the issue in the present case is whether claimant's wrist condition was medically stationary on November 10, 1997, the date of the most recent closure.

The precise issue in each case was whether claimant was medically stationary at the time of the *respective* claim closures. ORS 656.268(1) permits an insurer to close accepted claims when the compensable conditions have become medically stationary. The Board's September 26, 1997 order determined that the March 1996 Notices of Closure were premature. The statutory scheme allowed the insurer to again close the claim when it determined that the compensable condition had become medically stationary. *See Drews*, 310 Or at 143 (statutory scheme may expressly contemplate that successive proceedings may be brought, notwithstanding the finality of the first proceeding). Thus, although the issue concerning the March 1996 Notices of Closure was a final decision, the Board's September 26, 1997 order did not decide, and could not have decided, the propriety of the November 10, 1997 closure. We proceed to examine the propriety of the most recent closure, *i.e.*, whether claimant was medically stationary at that time.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether the insurer has prematurely closed this claim depends on whether claimant was medically stationary at the time of the November 10, 1997 Notice of Closure, without consideration of subsequent changes in his condition. *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985). Claimant has the burden of proving, by competent medical evidence, that his condition was not medically stationary at the time of closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624, 628 (1981).

The insurer accepted a disabling right wrist strain as a result of claimant's January 1991 injury. (Ex. 17). Claimant continued to have problems in the right wrist. X-rays in May 1991 showed chronic changes consistent with an old fracture of the radius and the ulna. (Ex. 20-3). Claimant had fractured his right arm when he was young and it had never completely set correctly. (Ex. 20-2). In July 1991, Dr. Appleby, claimant's treating orthopedist, recommended right wrist surgery. (Ex. 33). The proposed surgical procedure was an excisional arthroplasty of the distal ulna with tendon interposition, possible excision of a cyst. (*Id.*)

Dr. Appleby continued to recommend surgery in October 1991 and December 1992 because claimant's wrist had not improved. (Exs. 42, 50). In a deposition in March 1995, Dr. Appleby testified that his last examination of claimant had been in December 1992. (Ex. 53-4). Aside from the consideration of surgery, claimant had not been under any other treatment regimen. (Ex. 53-9). Dr. Appleby said that the principal objective of the surgery was to moderate claimant's residual pain problem and a secondary benefit might be to improve mechanical function. (Ex. 53-10).

Dr. Appleby reexamined claimant on May 1, 1995 and reported that his condition had not changed very much. (Ex. 54). He continued to recommend a distal ulnar hemiarthroplasty with a tendon interposition. (Ex. 54-2). He said that the surgical option would be dealing primarily with pain at the distal radioulnar or the ulnocarpal articulation. (*Id.*)

On June 19, 1995, Providence Vantage MCO wrote to Dr. Appleby, stating that it had determined that the proposed right distal ulnar hemiarthroplasty with tendon interposition was not medically necessary and surgery was not likely to decrease pain or improve function. (Ex. 56). The request for that surgical procedure was not approved. (*Id.*) The notice indicated Dr. Appleby had 30 days to file an appeal. (*Id.*) Dr. Appleby did not file an appeal. (Ex. 67-1).

On September 11, 1995, Dr. Appleby wrote to the insurer, stating that claimant had the options of surgery or "accepting the limitation of the problem." (Ex. 58). He agreed that there was no alternative treatment to be offered to claimant, other than surgery. (*Id.*) Dr. Appleby continued to recommend surgery on March 11, 1996. (Ex. 59).

Citing *Thomas E. Suby*, 50 Van Natta 718 (1998) (*Suby I*), the insurer argues that the unappealed 1995 MCO order represents a final determination that the proposed surgery is not a compensable medical service. On the other hand, claimant argues that the holding in *Suby* does not apply to this case. He argues that he was not a party to the dispute involving the MCO and he is not bound by the legal consequences of Dr. Appleby's failure to appeal the MCO decision.

In *Suby I* and *Thomas E. Suby*, 50 Van Natta 1088 (1998) (*Suby II*), we addressed the relationship between a Director's order that found a surgery not reasonable and necessary and the claimant's entitlement to temporary and permanent disability benefits related to that surgery. We found that the Director's final determination that the surgery in question was not reasonable and necessary broke the chain of causation between the accepted condition and any disability associated with that surgery. Thus, we found the claimant not entitled to any disability benefits related to the inappropriate surgery, whether those benefits were classified as procedural, substantive, temporary, or permanent.

We need not determine whether the MCO decision has a legally preclusive effect on the premature closure issue, because we are unable to find as a factual matter on the record before us, which now includes the unappealed MCO decision, a reasonable expectation of further material improvement in claimant's condition. Dr. Appleby has recommended the same surgery for claimant since 1991. Dr. Appleby agrees that there are no alternative treatments to be offered to claimant. In June 1995, the MCO refused to approve the surgery. Claimant did not appeal that decision. So far as this record discloses, claimant has not otherwise pursued the surgical option. The hearing in this case was held three years after the MCO decision and claimant still has not undertaken the surgery. *See Karen T. Mariels*, 44 Van Natta 2452 (1992) (where a claimant's medically stationary status is contingent upon undergoing recommended surgery, claim is not prematurely closed if the claimant refuses the surgery; rejecting assertion that post-closure approval by MCO of surgery is "admission" that claim was prematurely closed). Although claimant has not affirmatively refused the proposed surgery in this case[1], we find no evidence that claimant is willing to undertake the surgery absent MCO approval. *See*

[1] Under these circumstances, we conclude that claimant has not established a reasonable expectation of material improvement because he has not established that the surgery will take place.

ORS 656.245(4) ("[t]hose workers who are subject to the [MCO] contract shall receive medical services in the manner prescribed in the contract."); *see also Reed v. Del Chemical Corp.*, 26 Or App 733 (1976) (the claimant's failure to affirmatively pursue surgery over several years evidences unwillingness to undergo potentially curative treatment, therefore claim not prematurely closed).

Extent of Scheduled Permanent Disability

Claimant's alternative argument at hearing was that the March 12, 1998 Order on Reconsideration had incorrectly reduced his scheduled disability award to zero. Because the ALJ determined that the closure was premature, he did not address the issue of extent of disability awarded by the March 12, 1998 Order on Reconsideration.

The insurer's November 10, 1997 Notice of Closure awarded 14 percent (26.88 degrees) scheduled permanent disability for loss of use or function of his right arm. (Ex. 71). Claimant requested reconsideration. (Ex. 72). A medical arbiter examination was performed on February 14, 1998. (Ex. 74). A March 12, 1998 Order on Reconsideration determined that claimant was not entitled to any permanent disability. (Ex. 75).

On reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(13) (WCD Admin. Order 96-072). We rely on the most thorough, complete, and well-reasoned evaluation of claimant's injury-related impairment. *See Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, we find that Dr. Neumann, the medical arbiter, provided the most thorough and complete evaluation of claimant's permanent injury-related disability. Dr. Neumann examined claimant on February 14, 1998. (Ex. 74). He found that claimant's impairment findings were related to his old, unrelated fracture injury of his forearms. (Ex. 74-5). Dr. Neumann noted that claimant also had degenerative changes in the right wrist. (*Id.*) He attributed claimant's reduced wrist range of motion to residuals from the old fracture injury. (*Id.*)

Dr. Appleby examined claimant on May 1, 1995 and reported that claimant's right wrist range of motion findings were "dorsiflexion 50x, palmar flexion 42, ulnar deviation 25, radial deviation 12, pronation 52, supination 70x." (Ex. 54-1). On March 11, 1996, Dr. Appleby reported that claimant had noted some improvement in wrist discomfort. Dr. Appleby reported claimant's right wrist range of motion findings as "dorsiflexion 50x, palmar flexion 55x, radial deviation 18x, ulnar deviation 30x." (Ex. 59-1). He did not measure pronosupination at that time. (*Id.*) Dr. Appleby did not comment regarding the effect of claimant's old fracture injury on the reduced range of motion in either of those reports.

After considering the impairment findings from the medical arbiter, Dr. Neumann, and those made by Dr. Appleby, we conclude that Dr. Neumann provided the most reliable evaluation of claimant's right wrist impairment as of the date of issuance of the Order on Reconsideration. In previous cases, 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. *See, e.g., Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996). Here, we find that the time gap between Dr. Appleby's last evaluation (March 1996) and Dr. Neumann's medical arbiter examination (February 1998) was significant. Moreover, we conclude that Dr. Neumann's report is more complete and provided more probative evidence of claimant's disability as of March 12, 1998, the issuance date of the reconsideration order. Based on Dr. Neumann's report, we are not persuaded that claimant has impairment in his right wrist due to the accepted condition. Consequently, we affirm the March 12, 1998 Order on Reconsideration, which reduced claimant's scheduled permanent disability award to zero.

ORDER

The ALJ's order dated July 10, 1998 is reversed. The March 12, 1998 Order on Reconsideration that awarded no permanent disability is affirmed. The ALJ's attorney fee award is reversed.

Board Member Biehl concurring in part and dissenting in part.

I agree with the portion of the majority opinion that determined that the September 26, 1997 order was not preclusive and the statutory scheme allows the insurer to again close the claim. I disagree, however, with the majority's conclusion that claimant was medically stationary at the time of the November 10, 1997 Notice of Closure.

Since 1991, Dr. Appleby has consistently maintained that claimant should have an excisional arthroplasty of the distal ulna with tendon interposition. (Exs. 33, 42, 50, 53, 54, 58, 59). He felt that the surgery was reasonable and necessary to get claimant's right wrist in the best possible condition. (Ex. 53-5). Dr. Appleby testified that the surgery would ameliorate claimant's pain, which in turn would improve claimant's level of functioning by increasing his strength and ability to work. (Ex. 53-10, -11). Based on Dr. Appleby's opinion, I believe the recommended surgery is expected to materially improve claimant's right wrist condition. Therefore, claimant was not medically stationary at the time of closure.

Furthermore, I believe the majority's reliance on *Karen T. Mariels*, 44 Van Natta 2452 (1992), is misplaced. In that case, the claimant, at the time of closure, refused recommended surgery and we concluded that she had failed to prove that she was not medically stationary at closure. Here, in contrast, there is no evidence whatsoever that claimant has refused to have surgery. Nevertheless, the majority says it finds "no evidence that claimant is willing to undertake surgery absent MCO approval." The majority's comparison with *Mariels* is not persuasive. The majority is apparently concluding that claimant has to finance his own surgery in order to prove that he is willing to undergo surgery. As noted earlier, Dr. Appleby has consistently recommended surgery since 1991 and there is nothing in the record to indicate that claimant has hesitated or refused to have that surgery. Based on my review of the evidence, this claim was prematurely closed.

March 9, 1999 Cite as 51 Van Natta 397 (1999)

In the Matter of the Compensation of
ANNE C. FAKES, Claimant
WCB Case No. 97-10088
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's denial of claimant's 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.

We find Dr. Potter's opinion expressed in Exhibit 35 unpersuasive because he did not explain away previously expressed doubts about the cause of claimant's "combined" low back condition. *See Yann You*, 49 Van Natta 602 (1997), *aff'd mem* 152 Or App 248 (1998); *Michael A. Bracken*, 45 Van Natta 2126, 2127 (1993).

ORDER

The ALJ's order dated November 25, 1998 is affirmed.

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

This matter is before the Board on remand from the Court of Appeals. *Fred Meyer, Inc. v. Eggman*, 156 Or App 395 (1998). The court has reversed our prior order, *Brian M. Eggman*, 49 Van Natta 1835 (1997), which had set aside the self-insured employer's denial of claimant's aggravation claim for a low back condition. In reaching our conclusion, we reasoned that claimant was not required to prove diminished earning capacity to establish a compensable aggravation claim under ORS 656.273. Citing *Intel Corporation v. Renfro*, 155 Or App 447 (1998) (which holds that diminished earning capacity must be demonstrated to prove the compensability of an aggravation claim for an unscheduled condition), the court has remanded for reconsideration.

FINDINGS OF FACT

We continue to adopt the ALJ's "Findings of Fact," as supplemented in our prior order.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual and procedural background of the claim. In October 1991, claimant experienced a compensable low back injury, which the employer accepted as "low back and left leg pain secondary to a left L5-S1 herniated disc." Dr. Hubbard, claimant's then-treating physician, performed a hemilaminectomy, medial facetectomy, and disc removal at L5-S1.

On March 9, 1993, Dr. Hubbard released claimant to light duty work with restrictions on lifting, sitting, standing, bending and walking. (Ex. 142). Claimant returned to work at the employer. No light work was instituted. (Ex. 144-2). Claimant worked four hours per day at his regular job, which required occasional lifting of 60 pounds, bending and twisting. After performing this work, claimant's symptoms increased. In May 1993, claimant quit his employment because of increased pain with any lifting, bending and standing. (Tr. 7).

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

On January 18, 1994, Dr. Bald performed an arbiter's examination and concluded that claimant could perform light/medium work. (Ex. 148-4). A January 26, 1994 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 36 percent.

In January 1994, and again in June and July 1994, claimant sought treatment from Dr. Ball for low back and left leg pain. (Ex. 150). On August 25, 1994, claimant began treating with Dr. Demakas, neurosurgeon, for his low back and left leg condition. (Ex. 152). An October 1994 MRI revealed extensive epidural scarring at L4-5 and L5-S1 with nerve root displacement. (Ex. 153). On February 23, 1995, Dr. Demakas authorized time loss as of December 1994. (Ex. 156).

Drs. Andersen and Coletti, who performed a medical evaluation at the employer's request, concluded on May 3, 1995 that claimant's low back condition had not worsened since a previous examination in April 1993. (Ex. 157-4). The employer then denied claimant's aggravation claim on May 11, 1995. (Ex. 158).

On September 6, 1995, Dr. Heusner evaluated claimant's condition for Dr. Demakas. Dr. Heusner found epidural scarring and a recurrent disc at L5-S1 for which she recommended surgery. (Ex. 112). Dr. Heusner stated that claimant "is incapacitated and unable to resume tasks of daily living." *Id.*

On December 4, 1995, the employer issued another denial of aggravation on the ground that claimant had not used the proper form for her claim. (Ex. 163A). On December 21, 1995, claimant filed a formal claim for aggravation. On that form, Dr. Ball stated that claimant had been unable to work since June 23, 1994. (Ex. 165).

The ALJ found that claimant proved an "actual worsening" of his compensable 1991 low back injury claim. However, the ALJ concluded that claimant had not established a compensable aggravation claim because he failed to prove that the worsening resulted in a loss of earning capacity.[1]

Citing *Jason S. Palmer*, 48 Van Natta 2394 (1996), we held that an aggravation can be proved by medical evidence of an "actual worsening of the compensable condition," without regard to whether a worsening has resulted in diminished earning capacity. *Brian M. Eggman*, 49 Van Natta at 1836. Because the employer did not dispute the ALJ's finding that claimant's compensable L5-S1 condition had pathologically worsened, we concluded that claimant had proved an "actual worsening," thereby establishing a compensable aggravation claim. *Id.* We also rejected the employer's argument that claimant was not entitled to temporary disability because he was not in the labor market at the time of disability.

Citing *Renfro*, the court has now reversed and remanded for reconsideration of the diminished earning capacity issue. In accordance with the court's mandate, we now proceed with our analysis of that issue.

In *Renfro*, the court reversed our order in *Catherine G. Renfro*, 49 Van Natta 1165 (1997), that set aside a carrier's aggravation denial of the claimant's fistula condition. In doing so, we had concluded that the claimant was not required to prove diminished wage-earning capacity in order to establish a worsened condition involving an unscheduled body part under ORS 656.273(1).

The court disagreed. Relying on *Smith v. SAIF*, 302 Or 396 (1986), the court reiterated that, to establish a compensable aggravation of an unscheduled condition under ORS 656.273(1), a claimant must prove that the worsening of the condition resulted in diminished earning capacity. The court acknowledged that, because of 1990 and 1995 amendments, ORS 656.273 now requires "an actual worsening of the compensable condition supported by objective findings." Citing *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997), the court further recognized that "actual worsening" requires proof of pathological worsening of a claimant's condition. Nonetheless, noting that it had focused solely on "symptomatic" versus "pathological" worsening in *Walker*, the court reasoned that nothing in that case suggested that the legislature had intended to repudiate *Smith's* fundamental proposition that, to establish the compensability of an aggravation claim for an unscheduled condition, a claimant must prove diminished earning capacity.

Accordingly, the court held that, to prove a compensable aggravation of an unscheduled condition, a claimant must prove (1) an "actual worsening" of that condition that (2) results in diminished earning capacity. Because there is no dispute regarding the "actual worsening" aspect of this case, our focus here is on the diminished earning capacity issue.

In concluding that claimant had not suffered diminished earning capacity resulting from the "actual worsening" of his low back condition, the ALJ relied on the medical opinion of Dr. Andersen and Dr. Coletti, who examined claimant on the employer's behalf in April 1993, May 1995, and January 1996. Those physicians opined that claimant's low back condition had not worsened. Citing the examining physicians' "historical perspective," as well as Dr. Demakas's concurrence with the May 1995 report, the ALJ concluded that claimant had not suffered a diminished earning capacity. The ALJ also noted that Dr. Demakas in February 1995 declined to answer yes or no to a question about whether claimant was able to work. In addition, the ALJ discounted the opinion of Dr. Heusner, who opined that claimant was incapacitated and unable to resume tasks of daily living. The ALJ found Dr. Heusner's opinion unpersuasive because of her reliance on claimant's statements regarding his physical capabilities, which the ALJ found unreliable due to evidence of "nonorganic components" to claimant's disability.

We reach a different conclusion from the ALJ's. In determining that claimant had proved an "actual worsening," the ALJ had previously found the Anderson/Coletti opinions unpersuasive. We share this assessment of their opinions. Unlike the ALJ, we, therefore, do not rely on those same opinions in determining whether claimant's earning capacity had diminished.

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[1] The ALJ also increased claimant's unscheduled permanent disability award to a total of 40 percent.

Moreover, while it is true that Dr. Demakas concurred with the May 1995 Anderson/Coletti report that concluded that claimant's condition had not worsened, Dr. Demakas also disagreed with the January 1996 report from those doctors. (Ex. 168). Also, Dr. Demakas declined to answer a question regarding claimant's ability to work. Dr. Demakas emphasized, however, that the reason for this was that he did not do disability evaluations. (Ex. 156). Dr. Demakas nevertheless opined that claimant's ability to work was "markedly limited at best." *Id.* (emphasis in original).

Dr. Demakas also concurred with Dr. Heusner's report in which she concluded that claimant was incapacitated and unable to resume tasks of daily living. (Exs. 162, 163). The ALJ apparently believed that Dr. Heusner gave insufficient consideration to non-organic factors. Nevertheless, Dr. Heusner specifically noted that claimant had not exhibited many of the chronic behaviors that workers with low back injuries can develop. (Ex. 162). In light of his comment, we find that Dr. Heusner sufficiently addressed any concerns regarding non-organic/functional overlay. Because it is well-reasoned, Dr. Heusner's opinion is persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986).

Therefore, inasmuch as claimant's ability to work is "markedly limited at best," and because he is "incapacitated and unable to resume the tasks of daily living," we find that this record proves that claimant's ability to work has diminished from the light/medium capacity at the time of the 1994 claim closure as result of a pathological worsening of his low back condition. Accordingly, we conclude that claimant has proved a compensable aggravation claim under the *Renfro* standard.

The employer also contends that, even assuming claimant sustained a compensable aggravation claim, he is not entitled to temporary disability because he withdrew from the work force. Upon further consideration of this issue, we continue to conclude for the reasons cited in our original order that claimant was in the work force at the time of his disability and is, thus, entitled to temporary disability.

Finally, the employer argues that claimant is not entitled to temporary disability because there was no authorization from an attending physician. We are not inclined to address this issue because it was not clearly raised at hearing (Tr. 5) or previously argued on review. *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); *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).

Nevertheless, based on our review of the record, we conclude that Dr. Demakas was the physician primarily responsible for treatment of claimant's compensable conditions. (Exs. 155, 156, 161). Therefore, Dr. Demakas was the attending physician. *See* ORS 656.005(12)(b); *Debbie I. Jensen*, 48 Van Natta 1235, 1236 (1996) (whether a physician qualifies as an "attending physician" is a question of fact). In this regard, we note that the employer viewed Dr. Demakas as the attending physician because it sent copies of medical reports from the examining physicians to Dr. Demakas for his concurrence. (Exs. 159, 168). In addition, the employer sent a copy of its May 1995 denial to Dr. Demakas. (Ex. 158-2). Inasmuch as Dr. Demakas, as attending physician, authorized temporary disability on February 23, 1995 (Ex. 156), we find that claimant is entitled to temporary disability with claim reopening. The precise nature (partial or total) and amount of that temporary disability is a matter for future claim processing.

Because claimant has finally prevailed after remand, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. In our prior order, we awarded claimant's counsel an assessed fee of $4,000 for services at hearing and on review in prevailing over the employer's denial. ORS 656.386(1). We reinstate that award. Inasmuch as, following the employer's appeal and the court's remand, we have not disallowed or reduced the compensation awarded to claimant, his counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Court of Appeals and on remand. *See* ORS 656.388(1).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before the Court of Appeals and before the Board on remand is $3,500, payable by the employer.[2] In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief before the court and his supplemental briefs to the Board on remand), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

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[2] Thus, claimant's counsel's total attorney fee award for services rendered before the ALJ, Board, and court is $7,500, to be paid by the employer.

Accordingly, on remand, as supplemented and modified herein, we republish our October 16, 1997 order.

IT IS SO ORDERED.

March 10, 1999 Cite as 51 Van Natta 401 (1999)

In the Matter of the Compensation of
KRIS HENRIKSEN, Claimant
WCB Case No. 98-05866
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that declined to direct the SAIF Corporation to amend its acceptance of claimant's right-sided herniated cervical C5-6 disc to include "fatigue and loss of strength and reflex in the right upper extremity." On review, the issue is scope of acceptance. We affirm.

FINDINGS OF FACT

In September 1996, claimant noted the onset of neck pain while working on a construction project. In August 1997, an Opinion and Order found claimant's cervical condition compensable and directed SAIF to accept the claim. Thereafter, in September 1997, SAIF accepted a right-sided herniated cervical disc at C5-6.

After two surgeries, claimant was declared medically stationary on April 10, 1998. He then underwent a physical capacities evaluation (PCE). Among other things, the evaluator found slight atrophy in the right forearm and reduced strength and flexor reflexes in the right arm. Claimant's attending physician concurred with the PCE and opined that claimant's loss of strength was valid and due to the accepted condition.

On June 15, 1998, SAIF issued an Updated Notice of Acceptance, confirming its acceptance of claimant's right-sided herniated cervical disc at C5-6. In response to the updated acceptance notice, claimant's counsel requested that SAIF include as an accepted condition "fatigue and loss of strength and reflex in the right upper extremity." SAIF declined to do so, advising claimant's counsel that these were symptoms, not diagnoses and that, pursuant to ORS 656.262(7)(a), it was not required to accept each and every diagnosis or condition with particularity, so long as the acceptance reasonably apprised claimant and medical providers of the nature of the compensable condition. Claimant's counsel maintained that fatigue and loss of strength and reflex were conditions that should be formally accepted, and requested a hearing on SAIF's alleged *de facto* denial.

Meanwhile, the claim was closed pursuant to a June 30, 1998 Determination Order, which awarded temporary disability as well as 21 percent (67.2 degrees) unscheduled permanent disability and 21 percent (40.32 degrees) scheduled permanent disability (for loss of use or function of the right arm). SAIF requested reconsideration and a medical arbiter examination.

An October 14, 1998 Order on Reconsideration modified claimant's permanent disability award, awarding 25 percent (80 degrees) unscheduled permanent disability and 4 percent (7.68 degrees) scheduled permanent disability for loss of strength of the right arm.

CONCLUSIONS OF LAW AND OPINION

Following the hearing on the scope of acceptance issue, the ALJ found that claimant's right arm fatigue and loss of strength and reflex constituted symptoms rather than conditions, and denied claimant's request for relief.

On review, claimant contends that, pursuant to ORS 656.262(6)(d), SAIF is obligated to either amend its acceptance to include the right arm fatigue and loss of strength and reflex or at least clarify in writing that the right arm problems were included as part of the accepted cervical condition.

ORS 656.262(6)(d) provides that a worker who believes that a condition has been incorrectly omitted from a notice of acceptance must communicate its objection to the notice in writing to the carrier. Then the carrier has 30 days from the receipt of the worker's communication to "revise the notice or to make other written clarification in response."

Here, SAIF responded in writing within a week of claimant's counsel's June 16, 1998 letter requesting that claimant's right arm fatigue and loss of strength and reflex be included as an accepted condition. SAIF declined to issue an amended acceptance, asserting that the described right arm problems were symptoms of the accepted disc herniation rather than separate medical conditions or diagnoses. We find that SAIF's correspondence complied with the requirements of ORS 656.262(6)(d).

We also find that SAIF's response to claimant's counsel's letter was appropriate under ORS 656.262(7)(a)[1] because its acceptance of "herniated cervical disc, C5-6 right sided" reasonably apprised claimant and his medical providers of the nature of his compensable condition.[2] The uncontroverted medical evidence establishes that the right arm findings in dispute are due to the accepted condition. Based on the medical evidence in this record, these right arm findings do not, however, constitute a distinct medical condition or diagnosis that must be formally accepted in addition to the accepted disc herniation. *See, e.g., Royal S. Buell,* 50 Van Natta 702 (1998) (holding that a "crush injury" was a description of the mechanism of injury, and not a distinct medical condition or diagnosis from the claimant's accepted right hand injury). Consequently, we agree with the ALJ that SAIF is not required to amend the Notice of Acceptance.

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

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[1] This section provides, in pertinent part, that a carrier "is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant and medical providers of the nature of the compensable conditions."

[2] Even claimant's attending physician, who indicated that claimant's loss of strength was 100 percent due to the accepted condition, opined that SAIF's acceptance of "herniated cervical disc, C5-6 right sided" reasonably apprised medical providers of the nature of claimant's condition. (Exs. 25, 30).

In the Matter of the Compensation of
RON E. WEATHERS, Claimant
WCB Case No. 97-10360
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the insurer's partial denial of claimant's injury claim for a C5-6 disk herniation. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the finding that claimant gave Dr. Kirkpatrick a history of the acute onset of *severe* neck pain following the September 27, 1997 injury.

CONCLUSIONS OF LAW AND OPINION

To establish compensability of his C5-6 disk herniation, claimant must prove that his compensable injury is the major contributing cause of that condition. ORS 656.005(7)(a)(B).[1] This is a complex medical question that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). The record contains opinions from Drs. Dattilo and Kirkpatrick that support the compensability of the claim, and a contrary opinion from Dr. Fuller.

The ALJ concluded that the opinions of Drs. Dattilo and Fuller were not persuasive because they did not consider the potential contribution of claimant's preexisting degenerative disk disease. The ALJ further concluded that Dr. Kirkpatrick's opinion was not persuasive because it was based on claimant's inaccurate history of the acute onset of severe neck pain at the time of the compensable injury. In so concluding, the ALJ found that claimant was not a credible witness.

We affirm the ALJ's ultimate conclusion subject to the following alternative and supplementary rationale.

On review, claimant contends that Dr. Kirkpatrick's opinion persuasively establishes that his compensable injury is the major contributing cause of his C5-6 disk herniation. Specifically, claimant challenges the ALJ's finding that claimant was not a credible witness, and the finding that claimant gave Dr. Kirkpatrick an inaccurate history of the acute onset of *severe* neck pain at the time of the compensable injury. Claimant further contends that Dr. Kirkpatrick did not rely on such a history of severe neck pain, and that the ALJ erred in discounting his opinion on this basis.

We agree with claimant that the record does not support the ALJ's finding that claimant gave Dr. Kirkpatrick a history of the acute onset of *severe* neck pain at the time of the compensable injury. Rather, the record merely establishes that claimant reported an unqualified degree of neck pain at the time of the injury. Moreover, unlike the ALJ, we are unable to conclude that Dr. Kirkpatrick's opinion was premised on such a history of *severe* neck pain dating back to the compensable injury.

Nevertheless, the ALJ's adverse credibility finding is not dependent on claimant's alleged inaccurate history of severe neck pain. The ALJ also relied on claimant's lack of recall and evasive responses to questions at hearing, inconsistencies between claimant's testimony and contemporary chart notes documenting a marked improvement in claimant's neck pain prior to the off-work sneezing incident on November 11, 1997, and inconsistencies between claimant's testimony and that of other witnesses. In particular, the ALJ noted that claimant's denial of an off-work confrontation with a llama was inconsistent with the testimony of claimant's project manager and claimant's wife. These factors are a persuasive basis for finding that claimant was not a reliable or credible witness, independent of the history he gave regarding the onset of his neck pain.

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[1] Neither party challenges the ALJ's analysis of this claim under ORS 656.005(7)(a)(B), and the record supports that analysis.

Moreover, even if we assume that claimant testified in a credible manner, we would still conclude that Dr. Kirkpatrick's opinion does not satisfy claimant's burden of proof. We have concluded above that Dr. Kirkpatrick did not rely on a history of severe neck pain at the time of the injury. However, in his March 13, 1998 report, Dr. Kirkpatrick reasoned that claimant had "*all* the symptoms of a disk injury without radiculopathy" at the time of the compensable injury. (Emphasis provided). Then, in his subsequent deposition, Dr. Kirkpatrick defined the language "all the symptoms" as used in the March 13 report to include the acute onset of severe neck pain. Dr. Kirkpatrick's opinion is less persuasive because the record does not support such an acute onset of severe neck pain. Furthermore, in his deposition, Dr. Kirkpatrick gave inconsistent opinions regarding the contribution of claimant's preexisting degenerative disk disease. Specifically, Dr. Kirkpatrick first opined that the preexisting degeneration documented in claimants' x-rays would make him more prone to disk herniation. And later in his deposition Dr. Kirkpatrick stated that claimant's mild degenerative disk disease would not predispose him to herniation.

Finally, unlike the ALJ, we conclude that Dr. Fuller's opinion is entitled to some consideration. In particular, we disagree with the ALJ's position that Dr. Fuller did not consider the comparative contribution of claimant's degenerative disc disease. To the contrary, Dr. Fuller attributed claimant's disk herniation to the combined effect of the preexisting degeneration and the off-work sneezing incident on November 11, 1997. Dr. Fuller further explained that his opinion was consistent with claimant's preexisting degenerative disk disease, the absence of radicular symptoms and positive neurological findings following the compensable injury, and Dr. Tice's September 27, 1997 report of "no significant neck pain."

In summary, given the aforementioned weaknesses in Dr. Kirkpatrick's reasoning, and Dr. Fuller's contrary opinion, we conclude that the record does not satisfy claimant's burden of establishing the compensability of his cervical disk herniation by a preponderance of the evidence.[2] Thus, we agree with the ALJ's ultimate decision to uphold the insurer's denial.

ORDER

The ALJ's September 17, 1998 order is affirmed.

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[2] We adopt the ALJ's conclusion and rationale that Dr. Dattilo's opinion does not provide a persuasive basis for concluding that claimant's disk herniation is compensable.

In the Matter of the Compensation of
TREVOR MAUN, Claimant
WCB Case Nos. 98-05283 & 98-05282
ORDER ON REVIEW
Jerome P. Larkin (Saif), Defense Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Safeco Insurance Company, on behalf of its insured, Power Rents, Inc., requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of responsibility for claimant's right knee condition; and (2) upheld the SAIF Corporation's responsibility denial of the same condition issued on behalf of its insured, Bicmar Corporation.[1] On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside Safeco's denial of responsibility for claimant's right knee condition. In doing so, the ALJ reasoned that claimant probably sustained a re-torn meniscus on April 13, 1998 when he stepped down from a backhoe while working for Safeco's insured. Relying on the initial opinion of Dr. Oates, claimant's attending physician, that the April 1998 injury was the major contributing cause of claimant's current worsened knee condition, the ALJ set aside Safeco's denial and upheld SAIF's responsibility denial in connection with an October 7, 1997 right knee injury, accepted by SAIF as a medial meniscus tear. Claimant sustained that injury while working for SAIF's insured, Bicmar Corporation.

On review, Safeco contends that a preponderance of the medical evidence fails to establish that claimant sustained a re-tear of the right medial meniscus. Moreover, Safeco asserts that, even if he did, there is no persuasive evidence that the April 13, 1998 incident was the major contributing cause. For the following reasons, we find that the medical evidence is insufficient to shift responsibility for claimant's right knee condition from SAIF to Safeco.

The parties do not dispute, and we find, that claimant's current right knee condition involves the same condition (right medial meniscus) as SAIF's 1997 accepted claim. Therefore, because the 1997 and 1998 claims involve the "same condition," ORS 656.308(1) applies as to claimant's current condition "vis-a-vis" Safeco and SAIF.[2] *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371 (1993).

Under ORS 656.308(1), to shift responsibility to Safeco, SAIF has the burden to prove that the major contributing cause of claimant's current right knee disability or need for treatment was due to his injury on April 13, 1998, while Safeco was on the risk. *Liberty Northwest Ins. Corp. v. Senters*, 119 Or App 314, 317 (1993). SAIF contends that the opinion of Dr. Oates satisfies its burden of proof. We disagree.

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). Dr. Oates provides the only opinion on causation. In April 1998, Dr. Oates initially opined that claimant sustained a new

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[1] Claimant did not appear at the hearing.

[2] ORS 656.308(1) provides:

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

injury based on the April 13, 1998 incident. (Ex. 31). Dr. Oates believed that claimant sustained a re-torn medial meniscus, of which the April 1998 injury was the major contributing cause. (Ex. 32). After examining an MRI scan, however, Dr. Oates was unable to determine whether there had been a re-tear of the meniscus. (Ex. 39). Inasmuch as he could not find a "new injury" on the MRI and could only document the previous injury, Dr. Oates concluded that claimant sustained an exacerbation of the preexisting 1997 injury. *Id.*

Dr. Oates' next report further complicates matters. (Ex. 40). At one point, Dr. Oates stated that claimant had sustained a "possible" meniscus tear, but at another, he opined that there had been a "probable"re-tear. *Id.* Dr. Oates, however, once again stated that there had been an aggravation of the October 1997 injury. *Id.*

The medical evidence is, therefore, conflicting from Dr. Oates with respect to the presence of a "re-tear" of the medical meniscus.[3] Moreover, Dr. Oates' most recent opinion based on his review of the MRI scan indicates that claimant did not sustain a new injury, but rather an aggravation of the 1997 SAIF injury. This opinion does not support shifting responsibility from SAIF to Safeco. Because Dr. Oates no longer holds his earlier opinion that claimant sustained a "new injury" in April 1998, and because that opinion conflicts with his current opinion, we do not find that opinion sufficient to satisfy SAIF's burden of proving that claimant suffered a new compensable injury in April 1998; *i.e.* the record does not persuasively establish that claimant's April 1998 work incident while working for Safeco's insured was the major contributing cause of his need for medical treatment or disability for his current right knee condition. *See* ORS 656.308(1).

For these reasons, we reverse the ALJ's decision to set aside Safeco's denial and uphold SAIF's denial.

ORDER

The ALJ's order dated October 27, 1998 is reversed. Safeco's denial of responsibility is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing in accordance with law.

[3] The radiologist, Dr. Benedetti, opined that the MRI findings were most consistent with a "full-thickness" tear of the medial meniscus. (Ex. 36).

In the Matter of the Compensation of
LAURA M. RODELLO, Claimant
WCB Case No. 98-05711
ORDER ON REVIEW
Rasmussen & Tyler, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Black's order that awarded claimant's attorney an assessed fee of $2,500 for services at hearing. SAIF also moves to remand regarding the attorney fee issue. In addition, claimant requests that we sanction SAIF for filing a frivolous appeal. On review, the issues are attorney fees, remand, and sanctions.

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

Attorney Fees and Remand

The ALJ awarded claimant's attorney an assessed fee of $2,500 for services at hearing. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to draw conclusions from those facts in awarding an assessed attorney fee. SAIF requests that we remand the case to the ALJ to "properly" apply OAR 438-015-0010(4).

We considered SAIF's 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 Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *adhered to on recon* 327 Or 185 (1998),[1] 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make specific findings for each rule-based factor.

Nevertheless, here, the ALJ simply ordered SAIF to pay an assessed fee of $2,500.[2] Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4) that he relied on in determining a reasonable fee, we agree with SAIF that the ALJ's reasoning in arriving at the fee amount is not sufficient for our review. Nonetheless, 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.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

Here, SAIF requested, and the Director issued, an order suspending compensation pursuant to ORS 656.262(15) based on SAIF's contention that claimant failed to reasonably cooperate with the investigation of her occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. Subsequently, also pursuant to ORS 656.262(15), SAIF denied claimant's CTS claim on that basis. (Exs. 12, 13). The issue at hearing was whether claimant had unreasonably failed to cooperate with SAIF's investigation.

Claimant submitted a statement of services documenting that claimant's attorney spent 8.25 hours on the case. The hearing transcript was 36 pages. Claimant testified on her behalf, and one witness testified on SAIF's behalf. The record contains 15 exhibits, two of which were generated by claimant's attorney. There were no depositions.

Based on disputes generally litigated before this forum, we find the issue of whether claimant had unreasonably failed to cooperate with SAIF's investigation was of average complexity regarding the legal and factual issues involved. Because claimant succeeded in establishing that she did not

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[1] In *McCarthy*, on its own motion, the Court reconsidered its initial decision and clarified what it required of the Court of Appeals in explaining an attorney fee award in a civil case. 327 Or at 185. However, SAIF's arguments are solely limited to the Court's initial decision, without considering its explicit clarification on reconsideration. As we explained in *Underwood*, the Court's explanation on reconsideration is also enlightening in the context of what is required to explain an attorney fee award in a workers' compensation case.

[2] We note that claimant's counsel submitted a statement of services at hearing. On review, however, claimant does not contend that the ALJ's $2,500 assessed attorney fee award is inadequate. To the contrary, claimant argues that the record supports the attorney fee awarded by the ALJ and requests that the ALJ's order be affirmed in all respects. In addition, although arguing that the ALJ erred in failing to address each of the factors in OAR 438-015-0010(4) in awarding the attorney fee, SAIF did not submit to the ALJ any argument as to how the rule-based factors should be weighed in determining a reasonable fee. Nor does SAIF submit any such argument on review.

unreasonably fail to cooperate with the investigation, she is entitled to pursue the merits of her claim. If claimant had failed to meet her burden of proof, SAIF's denial would have been final, and she would not be permitted to attempt to prove the merits of her claim. Thus, the value of the interest involved and the benefit secured for claimant are significant. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented at hearing. Finally, based on the conflicting testimony, there was a risk that claimant's counsel's efforts might have gone 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 $2,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

Sanctions

On review, claimant requests that we sanction SAIF for filing a frivolous appeal. Claimant apparently contends that sanctions are appropriate because SAIF did not "preserve" the attorney fee issue for appeal. In this regard, claimant argues that, because SAIF made no response to her counsel's statement of services, which she submitted to the ALJ after the hearing, it should not be allowed to appeal the attorney fee award made by the ALJ.

ORS 656.390(1) provides that if a party requests review by the Board of an ALJ's decision and the Board finds that the appeal was frivolous or was filed in bad faith or for the purpose of harassment, the Board may impose an appropriate sanction upon the attorney who filed the request for review. "Frivolous" means that the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2); *see also Winters v. Woodburn Carcraft Co.*, 142 Or App 182 (1996).

We conclude that sanctions are not appropriate in this case. Claimant cites no support, and we find none, for her contention that SAIF is precluded from appealing the ALJ's attorney fee award because it did not object to her counsel's statement of services.[3] 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. Moreover, SAIF did not concede that claimant was entitled to a $2,500 assessed attorney fee for services at hearing. Therefore, we find that SAIF was not required to respond to claimant's attorney's statement of services in order to "preserve" the attorney fee issue for appeal. Furthermore, although we have found that $2,500 is a reasonable attorney fee for claimant's attorney's services on review, SAIF had a reasonable prospect of prevailing, *i.e.*, obtaining a reduced attorney fee award. Accordingly, we conclude that SAIF's appeal is not frivolous. Consequently, claimant's request for sanctions is denied.

Finally, claimant requests attorney fees for services on review. Claimant is not entitled to an attorney fee for services rendered defending an attorney fee award. *Dotson v. Bohemia*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated November 9, 1998 is affirmed.

[3] To the contrary, we find that case law supports a finding that SAIF is *not* precluded from appealing the ALJ's attorney fee award. In *Anthony Foster*, 45 Van Natta 1647, 1781, 1997, 2055 (1993), relying on *former* OAR 438-15-029(4), we held that, because the carrier did not submit a timely response to the claimant's counsel's statement of services, we would not consider its motion for reconsideration insofar as it pertained to specific objections to representations offered in the claimant's counsel's attorney fee request. Nevertheless, since the carrier had timely requested reconsideration of our order and raised the issue of the attorney fee award amount, we found it appropriate to reexamine that attorney fee award without considering the carrier's untimely contentions regarding particular portions of the claimant's counsel's statement of services. We note that, although the current version of *former* OAR 438-15-029(4) has been renumbered as OAR 438-015-0029(4), the relevant language is the same. Thus, even though a statement of services is not timely challenged under the rules, an ALJ's order (or a Board's order) may be challenged regarding the attorney fee issue. Furthermore, here, we necessarily did not consider any argument from SAIF regarding particular portions of claimant's counsel's statement of services because SAIF offered none.

In the Matter of the Compensation of
CHARLES C. COWGER, Claimant
WCB Case No. 98-04138
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of his head injury claim. On review, the issue is whether claimant's injury arose out of and in the course of employment. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a shipping supervisor, sustained injuries when he fell at work. Just prior to his fall, claimant was slowly jogging on pavement and reviewing inventory near railroad tracks. As he was jogging and looking off to the side, claimant suddenly fell, landing on the asphalt surface, knocking himself unconscious. No one witnessed the actual fall. Claimant had no recollection of what caused him to fall. The pavement where claimant fell was uneven and gradually sloped to a depth of approximately one to two inches where rain water collected. The surface, although wet, was not slick or frozen.

The ALJ upheld SAIF's denial, concluding that claimant failed to prove that his injury arose out of his employment. In reaching this conclusion, the ALJ reasoned that claimant failed to affirmatively prove that his injury was related to his work activity. *See* ORS 656.266; *Ruben G. Rothe*, 45 Van Natta 369 (1993).

On review, noting that there was no dispute that his injury occurred in the course of employment, claimant contends that, because the factors supporting the "course of employment" prong are "overwhelming," he need only show minimal factors supporting the "arising out of" prong of the work-connection test in ORS 656.005(7)(a). *See Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). Claimant asserts that he has easily satisfied the requirement of showing a minimal causal connection between his injury and his employment. He contends that running on uneven pavement while counting inventory (thus not allowing him to watch where he was stepping) created a risk of falling. Claimant asserts that circumstantial evidence concerning his fall meets his burden of affirmatively proving that his injury arose out of his employment. We agree.

For an injury to be compensable under the Oregon workers' compensation law, it must "aris[e] out of and in the course of employment." ORS 656.005(7)(a). The phrases "arise out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Hayes*, 325 Or at 596. This is called the "work- connection" test. *Id.* Under that test, both elements must be satisfied to some degree. *Id.* However, the two elements need not be met to the same degree. When the factors supporting one element are many, the factors supporting the other may be minimal. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

An injury arises out of employment where there exists "a causal link between the occurrence of the injury and a risk associated with [the] employment." *Norpac Foods Inc. v. Gilmore*, 318 Or 363, 366 (1994). A causal connection requires more than a mere showing that the injury occurred at the workplace and during working hours. *Id.* at 368; *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29 (1983). However, where the claimant's injury results from either an employment-related risk or a neutral risk that the employment put the claimant in a position to be injured, the injury is compensable under ORS 656.005(7)(a). *See, e.g., Henderson v. S.D. Deacon Corp.*, 27 Or App 333 (1994) (worker's injury when she stepped out of an elevator while attempting to leave the building for a lunch break was in the course and scope of employment); *see also Helen L. Good*, 49 Van Natta 1295 (1997) (the claimant's employment put her in a position to be injured where she was rushing to complete a task during the employer's busiest time of year).

In discussing "risks," the Supreme Court in *Redman Industries* and *Livesley* quoted with approval the following from 1 Larson's Workers' Compensation Law Sec. 7.00 at 3-14 (rebound ed. 1997):

> "All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and 'neutral' risks-- i.e., risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance." *Livesley*, 296 Or at 29-30.

In *Livesley*, the Court determined that unexplained injuries are a classic example of neutral risks. Because this case involves an unexplained injury, we find that it is best characterized as a "neutral risk." Neutral risks are those having no particular employment or personal character. *Redman Industries*, 326 Or at 36.

Here, there is no contention that the "course of employment" prong of the work connection test has not been met. Rather, SAIF argues only that claimant's injury did not "arise out of" employment. We disagree.

The evidence establishes that the area where claimant fell was a paved, but uneven, surface with gradual changes in level that resulted in water being collected in puddles. The uneven nature of the surface, combined with the fact that claimant was jogging and looking at inventory, exposed him to a risk of falling. Under these circumstances, we find a causal connection between claimant's work and his injury.[1] In addition, we find that, because the course of employment element is strongly satisfied, this compensates for any weakness in the "arising out of" prong. *See Krushwitz v. McDonald's Restaurants*, 323 Or 520, 531 (1996).

Accordingly, we conclude that claimant satisfied his burden of proving that his injury arose out of and in the course of employment. Because the ALJ concluded otherwise, we reverse.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 8, 1998 is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by SAIF.

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[1] We agree with claimant that the two cases on which the ALJ primarily relied, *Rothe* and *Pat Jennings*, 45 Van Natta 1191 (1993), are distinguishable. In contrast to *Rothe*, where the claimant was merely walking or standing on a concrete floor when he fell, and *Jennings*, where the claimant was standing on flat, asphalt-covered ground prior to his fall, claimant here was surveying inventory while simultaneously jogging on an uneven surface. Therefore, in contrast to *Rothe* and *Jennings*, we find that claimant's employment in this case significantly increased his risk of injury from falling.

In the Matter of the Compensation of
RICHARD FLORES, Claimant
WCB Case Nos. 96-09046 & 96-09044
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Wallace Klor & Mann, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Moller and Bock.

The SAIF Corporation, on behalf of DPR Construction (SAIF/DPR), requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); (2) upheld SAIF's responsibility denial, on behalf of Capital Concrete Construction (SAIF/CCC), of the same condition; and (3) awarded claimant an assessed fee of $6,547.50 pursuant to ORS 656.386(1) for claimant's counsel's services in obtaining a pre-hearing rescission of its compensability denial of claimant's bilateral carpal tunnel syndrome (CTS) claim. Claimant cross-requests review of that portion of the order that awarded a fee of $1,000 pursuant to ORS 656.308(2)(d), payable by SAIF/DPR. On review, the issues are responsibility and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

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

Claimant, working out of a union hall, was employed as a cement mason by numerous employers for 28 years, including SAIF/CCC from March through June 1994 and SAIF/DPR from February 26, 1996 through March 26, 1996, and again on April 8, 1996.[1]

On April 2, 1996, claimant sought treatment for bilateral wrist and hand complaints. Dr. Hoggard diagnosed bilateral carpal tunnel syndrome (CTS) and obtained confirming electrical studies.

On November 12, 1996, SAIF/CCC denied responsibility and requested an order pursuant to ORS 656.307. On October 17, 1996, as amended November 21, 1996, SAIF/DPR denied responsibility. On December 13, 1996, claimant requested a hearing on each of the denials. On March 13, 1997, a "307" order issued.

Claimant continued to work until April 9, 1997, when Dr. Franks performed a right carpal tunnel release; on May 7, 1997, Dr. Franks performed a left carpal tunnel release. The claim was closed with no award of permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ initially assigned responsibility for claimant's bilateral CTS condition to SAIF/DPR, the later employer, because SAIF/DPR was the last employer on the risk when claimant first sought treatment for that condition and the SAIF/DPR employment could have contributed to claimant's bilateral CTS. The ALJ then determined that SAIF/DPR could not avoid responsibility for claimant's bilateral CTS condition, because it failed to prove that it was impossible for its employment to have contributed to claimant's condition. Therefore, the ALJ concluded that SAIF/DPR remained responsible for claimant's bilateral CTS condition.

SAIF/DPR argues that the ALJ erred in finding it responsible for claimant's bilateral CTS because the medical evidence indicates that claimant's employment with SAIF/CCC was the major contributing cause of claimant's CTS condition, and, because actual causation was proven, it was not necessary to rely on the last injurious exposure rule to determine responsibility. We disagree.

The Court of Appeals addressed a similar argument in *Safeco Ins. Co. v. Victoria*, 154 Or App 574 (1998). The claimant in that case argued that the last injurious exposure rule should be applied only in cases where it is impossible to determine which employment is the major contributing cause of a claimant's compensable injury. In *Victoria*, as in this case, the parties agreed that the claimant's condition was compensable; thus, as here, the sole dispute was the assignment of responsibility. The court found the claimant's argument inapposite because it employed a principle of the last injurious

[1] All other potentially responsible employers were dismissed from the case.

exposure rule when it is used as a rule of proof (in contrast to the rule for assignment of responsibility). *Victoria*, 154 Or App at 577.

In this case, SAIF/DPR's argument that actual causation has been proven because the medical evidence shows that claimant's employment at SAIF/CCC was the major contributing cause of his CTS condition is likewise inapposite because it, like the claimant's argument in *Victoria*, is based on a principle of the last injurious exposure rule when it is used as a rule of proof. The rule of proof is not at issue in this case because all parties concede that claimant's CTS was work related and, therefore, compensable. There is, however, no restriction on SAIF/DPR's use of the last injurious exposure rule regarding the assignment of responsibility to attempt to shift responsibility back to SAIF/CCC. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244 (1984) (last injurious exposure rule is not "intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not.").

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim (unless the subsequent employment contributes independently to the cause or worsening of the condition). *Timm v. Maley*, 125 Or App 396, 401 (1993).

On this record, we agree with the ALJ's finding that claimant first sought treatment for his bilateral CTS during his SAIF/DPR employment. (*See* Exs. 4-4, 8). Consequently, presumptive responsibility is assigned with SAIF/DPR under the last injurious exposure rule of the assignment of responsibility.

In order for a carrier that would otherwise be held responsible under the last injurious exposure rule (*i.e.*, SAIF/DPR, because claimant first sought treatment for his bilateral CTS condition while working for SAIF/DPR) to shift responsibility to a prior carrier, the carrier that would otherwise be held responsible must still prove either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case; or (2) that the disease was caused solely by conditions at one or more previous employments. *Roseburg Forest Products*, 325 Or at 313 (1997); *Ruth L. Easley*, 50 Van Natta 2358 (1998), *on recon* 51 Van Natta 8 (1999); *Betty L. Martinez*, 50 Van Natta 1535, 1537 (1998).

In this case, Dr. Franks, claimant's attending neurosurgeon, initially opined that claimant's bilateral CTS was not *caused* by his work at SAIF/DPR, as it had arisen prior to his employment there. However, Franks also opined that, although claimant's right CTS had become symptomatic as early as 1994, and the left since 1995, the work claimant performed at SAIF/DPR would perpetuate or allow the bilateral CTS condition to continue, because he was performing the same types of work activities. (Ex. 66, 68-15, -27).

Dr. Rosenbaum, who examined claimant for DPR when a different carrier was on the risk, noted that claimant experienced an increase in hand discomfort for the two months prior to his April 2, 1996 examination. However, he was unable to identify a single employer as the primary contributor to claimant's CTS, opining that every employer since 1994 or before for whom he did general finishing work contributed to the development of the CTS. (Ex. 54).

Subsequently, Dr. Rosenbaum changed his opinion and stated that the major contributing cause of claimant's condition was his work at SAIF/CCC. He also opined that, because claimant denied symptoms of carpal tunnel syndrome while working for DPR, DPR did not cause or worsen the CTS. (Ex. 59). We are not persuaded by Dr. Rosenbaum's opinion, as it is not in accord with his own earlier finding that claimant had experienced worsening symptoms during SAIF/DPR's employment, which was based on the contemporary medical record. (*See* Exs. 8, 54).

Dr. Button and Dr. Hoggard agreed (as did Dr. Frank) that the major contributing cause of claimant's symptomatology and a threshold of pathological worsening was claimant's work at SAIF/CCC, not SAIF/DPR. (Exs. 57, 60). However, their opinions that the major contributing cause of claimant's condition occurred at SAIF/CCC neither proves nor disproves whether it was *impossible* for the employment exposure at SAIF/DPR to have caused or contributed to the claimant's condition or that the disease was caused *solely* by conditions that preexisted claimant's SAIF/DPR employment.

We conclude that the opinion of the attending physician, Dr. Franks, is the most persuasive medical opinion in this record. *Somers v. SAIF*, 77 Or App 259, 263 (1967) (medical opinions that are well-reasoned and based on complete and accurate histories are given greater weight). Thus, SAIF/DPR

has not established that the *sole* cause of claimant's bilateral CTS was work that preexisted his employment at SAIF/DPR. Accordingly, responsibility remains with SAIF/DPR. Finally, even if claimant had initially sought treatment for his compensable bilateral CTS condition while working for SAIF/CCC, the result would be the same because work activities for SAIF/DPR actually contributed to the compensable condition and, therefore, responsibility would shift forward to SAIF/DPR. *Spurlock v. International Paper Co.*, 89 Or App 461, 465 (1988).

Attorney Fees-Hearings Level

The ALJ awarded attorney fees totalling $7,547.50, payable by SAIF/DPR, of which $6,547.50 was assessed pursuant to ORS 656.386(1) for claimant's counsel's efforts in setting aside SAIF/DPR's denial of compensability prior to a decision by an ALJ, and $1,000 for services performed regarding the responsibility issue.

On review, SAIF/DPR contends that, because its denial was limited to responsibility, no attorney fee is allowed under ORS 656.386(1). In addition, SAIF/DPR argues that claimant should receive no more than an attorney fee of $1,000 to $2,000 under ORS 656.307(5). Claimant responds that his counsel is entitled to the full amount of $11,565 requested in his counsel's statement of services provided to the ALJ. Specifically, claimant contends that, because compensability was at risk until the "307" order issued, the ALJ's award made under ORS 656.386(1) was correct. In addition, claimant contends that an extraordinary fee is appropriate under ORS 656.308(2)(d).

Applicability of ORS 656.386(1)

In its October 17, 1996 denial, SAIF/DPR denied that claimant was a subject worker of SAIF/DPR on the putative date of injury, contending that it took place at a job site insured by a different insurer, and "[t]herefore, we must deny your claim." (Ex. 27). However, on November 21, 1996, SAIF/DPR amended its denial, acknowledging that claimant had performed work for SAIF/DPR at its work site, but that that employment was not the last injurious exposure. Although it did not contain a specific concession of compensability, the denial did specifically include the statement that "[t]he intent of this amended denial letter is to deny responisbility [sic] for your claim," and expressly notified claimant of SAIF/DPR's understanding that designation of a paying agent under ORS 656.307 had been requested. (Ex. 46).

SAIF/DPR's first denial denied compensability. However, based on the following reasons, we conclude that the November 21, 1997 amended denial essentially rescinded SAIF/DPR's "compensability" denial to deny responsibility only.

In *Ray L. Bennett*, 47 Van Natta 866 (1995), one of the carriers had issued a denial that stated, in part: "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above. Therefore, this letter represents a denial of responsibility for your current condition." In addition, the carrier's denial indicated that a paying agent had been requested.

Relying on *James D. Lollar*, 47 Van Natta 740 (1995), and *James McGougan*, 46 Van Natta 1639 (1994), we concluded that the carrier's denial in *Bennett* did not raise an issue of compensability. We found that the carrier's responsibility denial clearly and unambiguously conceded that the claim was compensable and indicated that responsibility was the only issue. Although the carrier's denial stated that it was a denial of the claim for benefits, we did not construe the denial to extend to compensability, given the express language conceding compensability and denying only responsibility.

We reached a similar conclusion in *Donald P. James*, 48 Van Natta 563 (1996). In its denial letter in *James*, the carrier stated that its denial was one of responsibility and notified the claimant that it had requested designation of a paying agent pursuant to ORS 656.307. Considering those factors, we did not construe the carrier's denial to extend to compensability, notwithstanding the lack of a specific concession of compensability.

Here, as in *James*, SAIF/DPR stated that it was denying responsibility and notified claimant of its understanding that designation of a paying agent pursuant to ORS 656.307 had been requested. Thus, as in *James*, notwithstanding the lack of a specific concession of compensability, we do not construe SAIF's amended denial to extend to compensability, considering the express language denying responsibility only, as well as the notation regarding the request for designation of a paying agent.

Based on the denial of compensability that was rescinded on November 11, 1997, an attorney fee under ORS 656.386(1) was possible, provided that claimant's counsel was "instrumental in obtaining a rescission of the denial." Here, claimant's request for hearing was not filed until after the amended denial issued. Therefore, the record shows no evidence of such services that would entitle claimant's counsel to a fee under ORS 656.386(1). Consequently, we reverse the ALJ's $6,547.50 attorney fee award.

Attorney Fee for Responsibility Issue

The ALJ awarded a $1,000 attorney fee under ORS 656.308(2)(d). However, because this case arises under ORS 656.307, 656.307(5), not 656.308(2)(d), applies. *See Dean Warren Plumbing v. Brenner*, 150 Or App 422, 427 (1997).[2] Thus, because the $1,000 limitation on attorney fees under ORS 656.308(2)(d) is inapplicable, claimant is entitled to a carrier-paid attorney fee for his attorney's active and meaningful participation in the "307" proceeding.[3] Therefore, we proceed to consider the factors in OAR 438-015-0010(4) in determining a reasonable attorney fee regarding the responsibility issue. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following. The issue in dispute was assignment of responsibility. Claimant's counsel successfully argued that SAIF/DPR, the later employer, should be found responsible. Thirty-two exhibits were received into evidence, one, apparently, generated by claimant's counsel. The hearing lasted approximately two hours, resulting in a 45-page transcript. Claimant provided oral closing argument. Claimant's attorney submitted a statement of services.

As compared to typical responsibility cases, the time devoted to the case was substantial, as demonstrated by claimant's counsel's statement of services. The responsibility issue in this case was of above average legal and medical complexity and involved multiple carriers prior to hearing. The value of the claim and the benefit secured are of average proportions, consisting of temporary disability and medical services. Claimant's counsel skillfully advocated claimant's claim in the face of a vigorous defense.

After considering the above factors, in particular the time devoted to the issue (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved, we find that a reasonable attorney fee for claimant's counsel's services at the "307" proceeding regarding responsibility for the bilateral CTS condition is $3,000, to be paid by SAIF/DPR. This award is in lieu of the ALJ's $1,000 attorney fee award.

Claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994). Moreover, claimant's right to compensation was not at risk of disallowance, because a "307 order" issued prior to hearing. Nor was claimant's right to compensation at risk of reduction. The ALJ assigned responsibility to SAIF/DPR and it had the lowest rate of compensation. (*See* Ex. 61A). Consequently, under these circumstances, claimant is not entitled to an assessed attorney fee under ORS 656.382(2) for services on review. *Long v. Continental Can Co.*, 112 Or App 329 (1992); *John H. Kirkpatrick*, 47 Van Natta 2105 (1995). Finally, claimant's attorney is not entitled to a fee for services related to securing the attorney fee award. *See Ernest C. Richter*, 44 Van Natta 101, *on recon* 44 Van Natta 118 (1992).

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[2] We are cognizant that SAIF/DPR argues that we should "take guidance" from ORS 656.308(2)(d) and limit claimant's attorney fee to $1,000. The standard provided under ORS 656.307(5) is, however, a "reasonable" fee. Therefore, we determine a "reasonable" fee based on the hearing record. *See Joann S. Robison*, 48 Van Natta 1699 (1996), *aff'd mem* 151 Or App 365 (1997) (ORS 656.308(2)(d) does not limit assessed fees awarded under ORS 656.307(5) for services rendered in a "307" responsibility proceeding).

[3] Claimant's attorney was instrumental in making a claim against SAIF/DPR (the responsible carrier). Moreover, claimant's counsel appeared at the hearing and actively and meaningfully participated in the proceeding by asserting that responsibility rested with SAIF/DPR.

ORDER

The ALJ's order dated May 29, 1998 is affirmed in part, reversed in part and modified in part. That portion of the order that awarded a $6,547.50 assessed attorney fee under ORS 656.386(1) is reversed. In lieu of the ALJ's $1,000 attorney fee award under ORS 656.308(2)(d), claimant's counsel is awarded a $3,000 attorney fee under ORS 656.307(5), payable by the SAIF Corporation, on behalf of DPR Construction. The remainder of the ALJ's order is affirmed.

March 11, 1999 Cite as 51 Van Natta 415 (1999)

In the Matter of the Compensation of
DEANA F. MARSHALL, Claimant
WCB Case No. 92-09708
THIRD ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Claimant requests reconsideration of our February 16, 1999 Second Order on Remand that: (1) set aside the SAIF Corporation's denial of claimant's occupational disease claim for a right shoulder and arm condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial and an allegedly unreasonable discovery violation. Claimant asserts that, now that she has finally prevailed on her claim for compensation, she is entitled to an award of attorney fees for services performed at all levels. With her request for reconsideration, claimant submits a copy of the "Petitioner's Petition for Attorney Fees on Appeal" that she submitted to the Court of Appeals on February 19, 1997.

Having received SAIF's response to claimant's reconsideration request, we withdraw our order for reconsideration.

This case has a long procedural history. The hearing in this matter was held on October 14, 1992. On January 13, 1993, an Administrative Law Judge (ALJ) issued an order that set aside SAIF's denial of claimant's right shoulder and arm claim. The ALJ found that ORS 656.128(3) was not applicable, holding that the statute requires corroborative evidence only of worker's compensation insurance coverage, not of compensability. Finally, the ALJ awarded an assessed attorney fee of $2,500 for services at hearing under ORS 656.386(1).

On review, we affirmed the ALJ's order and awarded a $1,000 assessed attorney fee under ORS 656.382(2). *Deana F. Marshall*, 45 Van Natta 1680 (1993). SAIF petitioned for judicial review.

On appeal, claimant's attorney researched and submitted a seven-page brief and prepared for and argued the case at oral argument. The Court of Appeals reversed our decision. *SAIF v. Marshall*, 130 Or App 507, *rev den* 320 Or 492 (1994). Reasoning that the statutory text provides that the corroborative evidence requirement pertains to "facts essential to the allowance or payment of claims for compensation, i.e., compensability," the court concluded that "[s]ole proprietors or partners making claims for compensation by virtue of ORS 656.128 must present corroborative evidence of compensability." *SAIF v. Marshall*, 130 Or App at 510. Therefore, the court remanded for reconsideration. Claimant's counsel filed three pages of argument in a petition for review to the Oregon Supreme Court, which the Court denied.

On remand before the Board, claimant's attorney researched and submitted a seven-page brief. We rejected claimant's argument that the medical histories in the medical reports provided corroborative evidence of compensability. *Deana F. Marshall*, 47 Van Natta 1686, 1688 (1995). We concluded that the medical reports corroborated the existence of a medical condition, but they did not corroborate the cause of that condition. *Id.* Therefore, we reinstated SAIF's denial of the claim. Claimant petitioned for judicial review.

On appeal, the Court of Appeals reversed our decision, finding that the medical reports corroborated compensability of the claim. *Marshall v. SAIF*, 146 Or App 50 (1997). Claimant's attorney submitted a February 19, 1997 fee petition to the Court of Appeals documenting 16 hours spent preparing the appellant's brief and preparing for and attending oral argument. SAIF appealed the court's decision.

On appeal, the Oregon Supreme Court affirmed the Court of Appeals. *Marshall v. SAIF*, 328 Or 49 (1998). The Court held 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." 328 Or at 57 (emphasis in original). Applying that rationale, the Court concluded that claimant's attending physician's medical reports provided sufficient corroboration of the *existence* of her tendinitis claim and likewise corroborated her assertion that the tendinitis was *work-related*. *Id.* at 58. Therefore, the Court reversed our order and remanded the case to us for further proceedings. In addition, the Court issued an appellate judgment that included, *inter alia*, an attorney fee award of $1,387.50 for services before the Court.

In our February 16, 1999 Second Order on Remand, in light of the Court's determinations, we found that claimant had established the compensability of her claim. Consequently, as supplemented and modified by the Supreme Court's opinion and by our February 16, 1999 order, we adopted and affirmed those portions of the ALJ's January 13, 1993 decision that: (1) set aside SAIF's denial of claimant's occupational disease claim for a right shoulder and arm condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial and an allegedly unreasonable discovery violation.

That brings us to claimant's request for reconsideration of our February 16, 1999 order. With her request for reconsideration, claimant submits a copy of the February 19, 1997 petition she submitted to the Court of Appeals, in which she requested an attorney fee award of $2,450 for services rendered regarding the second appeal to that court.[1] At that time, the court declined to award a fee because claimant had not yet finally prevailed. Claimant contends that, now that she has finally prevailed on the compensability issue, she is entitled to attorney fees for each level of review. We agree.

Inasmuch as claimant has prevailed finally after remand from the Supreme Court with regard to the compensability issue, she is entitled to a reasonable assessed attorney fee for her counsel's services before every prior forum. ORS 656.386(1); 656.388(1); *Mark L. Hadley*, 47 Van Natta 725 (1995).

In determining a reasonable fee, we apply the factors in OAR 438-015-0010(4). As summarized above, this case involved many appeals and forums, going before an ALJ, before the Board three times, before the Court of Appeals twice, and before the Supreme Court once. At each level, the attorneys on both sides skillfully represented their clients. Thus, the case required significant time and effort. The issue involved dealt with complex statutory interpretation in that the applicable provisions of ORS 656.128 had never before been interpreted. The value of the interest involved and the benefit secured is significant in that claimant will obtain benefits for her right shoulder and arm condition. The nature of the proceedings was complex, requiring advocacy before several forums, including both written briefs and oral argument. There was great risk that claimant's attorney's efforts might go uncompensated, given the complex statutory construction issue involved and the many appeals. Finally, there was no assertion of frivolous issues or defenses.

After considering all of these factors, we determine that a reasonable fee for claimant's attorney's services before all forums is $10,337.50, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, the skill and standing of counsel, and the risk that counsel may go uncompensated.

In reaching this determination, we note that SAIF neither contested during its prior appeals nor during this remand the following attorney fees: (1) the ALJ's award of $2,500 for services at hearing; (2) our award of $1,000 for services during our initial review; (3) claimant's counsel's petition to the Court of Appeals for a $2,450 award for services rendered before that forum in 1997; and (4) the Supreme

[1] We note that SAIF submitted a response to claimant's motion for reconsideration and petition for attorney fees. In that response, SAIF's attorney stated: "Claimant has provided sufficient information to justify an attorney fee for $2450.00. SAIF and the employer do not object to that amount as a reasonable attorney fee in this case."

Court's award of $1,387.50.[2] Finally, based on the factors described above (particularly the time devoted to the compensability issue, the complexity of the issue, the value of the interest involved, the skill and standing of counsel, and the risk that counsel may go uncompensated), we find that $3,000 is a reasonable additional attorney fee for claimant's counsel's services during the first round of appeals to the Court of Appeals and the Supreme Court, as well as during the first remand to the Board.[3]

In conclusion, on reconsideration, we find that a reasonable attorney fee award for claimant's attorney's services at all levels (including judicial reviews) is $10,337.50, payable by SAIF. Accordingly, as supplemented and modified herein, we republish our February 16, 1999 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] 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 Second Order on Remand), the Court already granted claimant a $1,387.50 fee for services rendered before that forum when it remanded the case to us for further proceedings. Because claimant had not yet prevailed at that time, the Court's award was effectively "conditional" in nature. *David Converse*, 50 Van Natta 2067 (1998) (court remanded on merits and granted the claimant a specified attorney fee for services rendered on judicial review, conditioned on the claimant prevailing on remand; Board found claim compensable on remand and awarded attorney fees for services at hearing and on review, in addition to the specified "conditional" attorney fee awarded by the court); *Gene H. Gosda*, 50 Van Natta 2279 (1998) (same). 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 a $1,387.50 award represents a reasonable fee for claimant's attorney's services performed before the Supreme Court.

[3] No services were provided during the second remand to the Board.

In the Matter of the Compensation of
ROBERT A. JAMES, Claimant
WCB Case No. C9-00341
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

On February 8, 1999 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on February 8, 1999. The statutory 30th day following the submission is March 10, 1999. Claimant filed his request for disapproval of the disposition on March 8, 1999. Accordingly, we disapprove the disposition. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
DURWOOD W. McDOWELL, Claimant
WCB Case No. 97-06277
ORDER ON REVIEW
Kirby, Johnson, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its partial denial of claimant's current back condition. On review, the issue is compensability.

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

The ALJ concluded that claimant's compensable injury remained the major contributing cause of his current disability or need for treatment. Specifically, the ALJ concluded that claimant's compensable injury combined with a psychological condition, but that the industrial injury remains the major cause of his current disability and need for treatment. In so finding, the ALJ relied on the opinion of claimant's treating physician, Dr. Euhus, as well as that of Dr. Schoenfelder.

Although we agree with the ALJ that claimant has established the compensability of his current condition by a preponderance of the evidence (particularly the opinions of Drs. Euhus and Schoenfelder), we are not, on this record, persuaded that claimant's original injury "combined" with a psychological condition for purposes of ORS 656.005(7)(a)(B). In the context of ORS 656.005(7)(a)(B), a "combined condition" means that an otherwise compensable injury has combined with a preexisting condition to cause or prolong disability or a need for treatment. In this case, however, there is no evidence establishing that claimant had a preexisting, underlying psychological problem that combined with his back injury. Rather, we are persuaded by the medical evidence (particularly the opinion of Dr. Schoenfelder) that, to the extent claimant's current condition has a psychological component, that psychological problem developed subsequent to his injury and is related to his many years of chronic pain.

We need not decide, however, whether claimant has a consequential psychological condition for purposes of ORS 656.005(7)(a)(A) because claimant has not made a claim for such a consequential condition and, in any event, we are persuaded that claimant's 1981 compensable injury remains the major contributing cause of his current disability and need for treatment.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Claimant's counsel has submitted a statement of services, requesting a fee of $7,645 for services on review. SAIF has objected to claimant's statement of services, asserting that the time spent in preparing the brief and the requested fee itself is excessive.

In awarding a reasonable attorney fee, we consider the factors set forth in OAR 438-015-0010(4).[1] In this case, claimant has submitted a detailed statement of services, showing that he spent 69.5 hours on this matter after requesting review. We note, however, that not all of these legal services were directed toward preparation of the respondent's brief. Further, the amount of time devoted to the case is but one of many factors to be considered in determining a reasonable attorney fee.

This case involved issues of above average complexity, considering the range of cases generally submitted to this forum (*i.e.*, the compensability of claimant's current condition, involving a 1981 compensable injury, an alleged psychological condition and a long history of chronic back pain). The medical record is voluminous. The value of the interest involved and the benefit secured are also above

[1] This rule requires us to consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue 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.

average, because claimant continues to experience exacerbations and seek treatment for his back condition. The parties' respective counsel's presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Also, based on the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our consideration and application of the factors set forth in OAR 438-0150010(4), we conclude that $4,400 is a reasonable fee for services on review. We note that claimant is not entitled to a fee for services related to the attorney fee issue. *Amador Mendez*, 44 Van Natta 736 (1992) (the claimant's counsel's services in litigating entitlement to an attorney fee award were not considered in determining the award).

ORDER

The ALJ's order dated September 28, 1998 is affirmed. For services on review, claimant's counsel is awarded $4,400, payable by SAIF.

March 11, 1999 Cite as 51 Van Natta 419 (1999)

In the Matter of the Compensation of
DONALD D. PAUL, Claimant
WCB Case No. C9-00057
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Coughlin, et al, Claimant Attorneys
Barbara A. Woodford, Defense Attorney

Reviewed by Board Members Bock and Haynes.

On January 25, 1999, 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 February 24, 1999, we received claimant's letter "appealing" the CDA. We treat claimant's letter as a motion for reconsideration of the approved CDA.[1] 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 January 25, 1999. We received claimant's letter on February 24, 1999, 30 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.

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[1] We note that claimant's letter also sought review of an Order of Dismissal of claimant's hearing request based on the approved CDA (WCB Case No. 98-08592). Claimant's request for review of the Order of Dismissal has been acknowledged. A briefing schedule will soon be established in that case to allow the parties to present their respective written arguments concerning the propriety of the Administrative Law Judge's (ALJ's) order. In other words, at that time, claimant can provide his written explanation regarding why he believes that the ALJ erred in dismissing claimant's hearing request following the Board's approval of the parties' CDA. Following submission of the parties' written arguments or the expiration of the briefing schedule (whichever occurs first), we will proceed with our review of the ALJ's order.

In the Matter of the Compensation of
HILARIO E. RIVERA, Claimant
WCB Case No. 98-02594
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the SAIF Corporation's denial of his left knee injury claim. On review, the issue is compensability.

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

Claimant contends that the ALJ erred in concluding that, due to the existence of a preexisting condition, claimant must prove that his work activity on November 11, 1997 was the major contributing cause of the combined condition. Rather, claimant argues that his claim is compensable because he established that his work activity was the major cause of his need for treatment or disability. We disagree.

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.

After our review of the record, we agree with the ALJ's application of the aforementioned standard of proof. The ALJ concluded that even if one accepted claimant's description of his work activities leading to "the immediate onset of symptoms, claimant has proven only that this activity was a precipitating event, but not the major contributing cause of the torn medial meniscus" for which he sought treatment from Dr. Kaesche. The ALJ's conclusion is supported by Dr. Kaesche's finding of degenerative joint disease within the knee and a degenerative condition within the torn meniscus. (Ex. 4, 12-6). Kaesche opined that claimant's work incident and degenerative condition within the meniscus combined to result in the torn meniscus, which was the major contributing cause of claimant's need for treatment. (Ex. 8).

When discussing the torn meniscus, although Kaesche agreed with claimant's hypothetical (that the degenerative tear in the meniscus extended to the surface of the meniscus at the time of the work incident and was the major contributing cause of the need for treatment), he continued to explain that, under the actual circumstances of the development of claimant's torn meniscus, the work incident was the precipitating cause of his torn meniscus and need for treatment. (Ex. 12-9, -10, -11, -12, -16, -17, -18, -19). Accordingly, when considered in its entirety, Dr. Kaesche's opinion does not establish that claimant's November 1997 work incident was the major contributing cause of the disability or need for treatment for his combined left knee condition (his meniscal tear). *See SAIF v. Britton*, 145 Or App 288, 293 (1996) (finding that work incident caused pathological worsening of preexisting carpal tunnel condition does not establish that incident is major contributing cause of need for treatment of combined condition); *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997) ("1995 amendments to ORS 656.005(7)(a)(B) make it clear that it is the primary cause of the disability or need for treatment of the *combined condition* that must be determined." (Emphasis in original)).

ORDER

The ALJ's November 18, 1998 order is affirmed.

In the Matter of the Compensation of
BETTY J. RICHMOND, Claimant
WCB Case No. 98-03637
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
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 claim for a torn medial or lateral meniscus of the right knee. On review, the issue is the procedural validity of SAIF's denial.

We adopt and affirm the ALJ's order with the following supplementation to address additional arguments that were not raised at hearing.

On review, claimant argues that SAIF's denial is a nullity because the claimed condition did not require medical treatment. The need for medical treatment is a relevant consideration in determining the *compensability* of a claim under ORS 656.005(7)(a). However, the existence of a "claim" does not depend on the presence or absence of medical treatment.

Claimant also argues that the denial is a nullity because SAIF formally denied the claim on causation grounds and did not expressly contend that the claimed condition does not exist. Claimant reasons that SAIF is bound by the express language of its written denial and, thus, cannot rely on evidence that the condition does not exist. *See Tattoo v. Barrett Business Services*, 118 Or App 348, 351-352 (1993) (carrier bound by the express language of its denial).

To begin, there is no evidence in this record that claimant argued at hearing that SAIF is bound by the express terms of its denial. Consequently, we are not inclined to address this issue on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). *Accord Roger Eli*, 47 Van Natta 1938 (1995).

In any event, we disagree with claimant's contention that SAIF's amendment was invalid. The court has held that *Tattoo* did not hold that a carrier could not amend its denial at hearing. *See SAIF v. Ledin*, 149 Or App 94 (1997). Here, in his opening remarks at hearing, counsel for SAIF amended its denial to challenge the existence of the claimed condition. Moreover, claimant did not request a continuance or otherwise object to this amendment.[1] The sanction for failing to issue a timely written denial does not include a prohibition against raising affirmative defenses, provided that those defenses are timely raised at hearing, and the claimant has the opportunity to request a continuance to cure any surprise or prejudice. *Sandra M. Goodson*, 50 Van Natta 1116 (1998).

ORDER

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

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[1] A party's remedy for surprise and prejudice created by the amendment of a denial at hearing is a motion for continuance. OAR 438-006-0031, OAR 438-006-0036 and OAR 438-006-0091.

In the Matter of the Compensation of
CHARLES COOPER, Claimant
Own Motion No. 99-0014M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's December 3, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from December 2, 1996 through November 11, 1998. The employer declared claimant medically stationary as of November 11, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the December 3, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a January 20, 1999 letter, we requested that the employer 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 January 25, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Claimant contends that he is not medically stationary because he is still under a doctor's care and that his doctor "has never released me to return to work and if he did I could not return to my job due to the pain in my knee." In a November 5, 1998 report, Dr. Hikes, claimant's attending physician, opined that claimant was medically stationary and that he did not expect further improvement with further passage of time. This medical opinion is unrebutted.

The definition of medically stationary outlines the criteria by which a physician must determine a claimant's medically stationary status. *See* ORS 656.005(17). Therefore, although claimant asserts that he is unable to work and is disabled, the pivotal question is whether his condition was medically stationary. In other words, has his condition, in the opinion of the medical experts, reached a state where it will not improve with further treatment or the passage of time? The answer to that questions is "yes."

Based on the uncontroverted medical evidence (*i.e.* the opinion of his attending physician), we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's November 11, 1998 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDY C. FERLAND, Claimant
WCB Case No. 97-08315
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a herniated lumbar disc condition. On review, the issue is compensabilitiy. We reverse.

FINDINGS OF FACT

Claimant had no low back problems or treatment for his low back before his 13 year work exposure with the employer. During the first year of this employment, claimant worked as a "shagger," moving vehicles. After that, he worked on the truck production line, then installing parts. For almost ten years, claimant performed physically taxing repetitive activities, including lifting and positioning truck bed parts. He lifted and attached bumpers, positioned truck beds on frames, attached bed bolts and mud flaps, and often worked in a cramped pit under the vehicle. Claimant's work activities included awkward lifting and torquing of his low back, as well as flexing, bending, twisting, extending, pushing and pulling with his lumbar spine. He worked on up to 120 vehicles in a 10 hour day.

Claimant developed low back pain while he worked on truck beds, but he did not seek medical treatment or miss work time. Then (in 1994 or 1996) claimant became a parts installer. This work included installing spoilers, running boards, tow hitches, mud flaps, drop hitches, and building and installing roof racks. Parts installation was somewhat less strenuous than truck bed assembly, but it still required repetitive lifting, flexing, bending, twisting, extending, pushing and pulling involving his low back. During the time claimant installed parts, the employer improved some of the tasks ergonomically.

In early 1995, claimant sought treatment for a lumbosacral strain or overuse syndrome and the employer accepted his claim. He treated conservatively and performed modified work, but his low back pain continued and worsened. He developed right sided low back pain, then right leg pain.

In April and May 1997, claimant was off work for eight weeks for bilateral carpal tunnel surgery. His low back pain did not subside during this time and he sought treatment again in July 1997.

On October 1, 1997, the employer denied claimant's claim for an "L5-S1" herniated disc. On October 22, 1997, claimant had surgery for an L4-5 herniated disc. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial in part because "claimant's lumbar disease process preexisted the onset of his initial claim filing," citing ORS 656.802(2)(b). The ALJ also found the opinion of Dr. Browning, treating physician, unpersuasive for three reasons. First, the ALJ reasoned that Dr. Browning had an inaccurate history regarding the onset of claimant's low back symptoms, because she was not aware that claimant first reported low back pain after he started working as a parts installer. Second, the ALJ discounted Dr. Browning's opinion because she reviewed only a portion of the videotapes of claimant's work activities, while the examining physicians "reviewed all available evidence." Finally, the ALJ reasoned that Dr. Browning's opinion was unpersuasive because she did not address the effects of claimant's preexisting disease process and never "offered an opinion that claimant's work activities were the major cause of a worsening of his combined condition." We disagree with the ALJ's reasoning and reverse his decision.

We note at the outset that there is no evidence that claimant's low back degeneration preexisted his work exposure with the insured. Under these circumstances, claimant did not have a "preexisting" condition within the meaning of ORS 656.802(2)(b).[1] *See New Portland Meadows v. Dieringer*, 153 Or App

[1] ORS 656.802(2)(b) provides:

"If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005 (7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

383, 387 (1998); *Ruth L. Easley*, 50 Van Natta 2317 (1998), *on recon*, 51 Van Natta 8 (1999). To prove his claim, claimant must establish that repetitive traumatic work activities for the insured were the major contributing cause of his L4-5 herniated disc condition.[2] *See* ORS 656.802(2)(a).

Dr. Browning provides the medical evidence supporting the claim. The dispositive question is whether her opinion is persuasive. We first evaluate the accuracy of Dr. Browning's history regarding claimant's symptoms and his work activities.

The record indicates that claimant's low back problems began after he started working for the insured and they worsened progressively during his employment. (Exs. 86-2; 87). There is no suggestion of contributory off-work activities or injuries. The medical evidence discussing the timing of the onset of symptoms suggests that the *exact* onset would be medically significant only if claimant had suffered an *abrupt* onset, a discrete injurious event. (*See* Exs. 72, 92). There was no such event in this case. Claimant eventually sought treatment for low back pain after he had endured it for some time. (Exs. 44-1; 72-2; 86-2; 87-2). Claimant's failure to "pin point" a specific date when his low back problems began is medically explained (and understandable), because the onset was insidious and the condition progressed gradually. (*See* Exs. 60-2; 61-11-12; 88-1; *see also* Ex. 77-1). Moreover, Dr. Browning eventually correctly understood that claimant had low back pain (and right leg pain) before he was off work for carpal tunnel surgery in 1997. (*See* Ex. 88-1; *see also* Tr. 27, 39, 41, 43; Ex. 61-13). Under these circumstances, we conclude that Dr. Browning had a materially accurate history regarding claimant's low back symptoms.

The ALJ discounted Dr. Browning's opinion in part because he found that she did not review *all* the available videotapes depicting claimant's work activities. But the parties agree that claimant's work activities over the years *did* involve repetitive traumatic activities involving his low back and Dr. Browning meticulously reviewed these activities in detail. (*See* Exs. 1, 87; Tr. 49-50). The employer does not contend that Dr. Browning had an inaccurate or incomplete history regarding claimant's work activities.[3] Moreover, because Dr. Browning's history regarding claimant's work is consistent with the employer's job descriptions and claimant's reporting, we conclude that it is accurate.[4]

We note that the ALJ's third reason for discounting Dr. Browning's opinion was that the doctor did not address claimant's preexisting disease process. But claimant had no such condition. Accordingly, we disagree with the ALJ's reasoning regarding Dr. Browning's opinion and proceed to further evaluate the medical evidence on *de novo* review.

Dr. Browning first saw claimant in July 1997 and reported that, in April 1997, claimant developed "insidious onset of pain in the left buttock radiating to posterior thigh and intermittently to the left heel." (Ex. 44-2). She opined:

> "Although there is no one-time injury incident, [claimant] has to bend and lift repetitively at his job. Therefore, his condition may be considered a cumulative trauma event. He works the P-line and Key-100 line installing roof racks, drop hitches, running boards, mud flaps." (Ex. 44-2).

After claimant's next two visits, Dr. Browning reported claimant's "ongoing pain since end of last year which has worsened since April" and "probable one year history of low back [pain] radiating to right leg pain." (Exs. 48-1, 53-2).

Drs. Dinneen and Platt examined claimant on September 23, 1997 and related his low back problems to "spontaneous" degenerative changes (noting that claimant reported no "specific incident"). (Ex. 72). Dr. Browning was "uncomfortable signing off on the IME and simply attributing the herniated disk to a degenerative process." (Ex. 75-1). She told claimant that "he falls into the 'gray zone'. . .as to work relatedness" and asked the employer to provide videotapes of line work activity. (*Id*).

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[2] The employer does not challenge the claim on other grounds.

[3] At one point, the employer apparently provided Dr. Browning videotapes depicting work activities *after* ergonomic improvements. But Dr. Browning was not ultimately misled or confused about the nature of claimant's work activities. (*See* Exs. 87-2-3; 89-9-13).

[4] Medical evidence based on a mistaken belief that claimant did *not* perform such activities at work is based on an inaccurate history. (*See* Ex. 91).

On October 29, 1997, Dr. Browning stated that she was unable to say that claimant's L4-5 herniated disc was primarily work related, because she was under the impression that his "low back pain radiating to his right leg" began while he was off work for carpal tunnel surgery in 1997. (Ex. 84-1). She also concurred with the examiners' September 23, 1997 opinion. (*Id.*; Ex. 85). Then, after reviewing a video of claimant's worksite and fine-tuning her understanding of claimant's work activities, Dr. Browning was undecided about causation, pending discussion with Dr. Ono, treating surgeon.[5] (Exs. 86-2; 87A-2).

After further reviewing claimant's history, Dr. Browning correctly understood that claimant had back pain while working on truck beds, long before his carpal tunnel surgery. (Ex. 87-1-2). Based on this corrected history, Dr. Browning revised her causation opinion and retracted her prior concurrence with Drs. Dinneen and Platt. Dr. Browning noted claimant's explanation that the video she and claimant saw depicting parts installation did not "'show anything [workers] had to go through before the work ergonomics came up' (referring to [claimant's] truck bed work which has been discontinued)." (Exs. 87-2-3; 89-11). She also noted that she had learned that claimant had right leg pain for about two years *before* his carpal tunnel surgery. (Ex. 88-1; *see* Tr. 27, 39, 41, 43; Ex. 61-13). Based on this revised (and accurate) history, and Dr. Ono's input,[6] Dr. Browning explained how and why she changed her opinion and ultimately concluded that claimant's work activities were the major contributing cause of his herniated disc. (Ex. 89-6-15). Specifically, Dr. Browning explained that claimant's work activities, "especially in the first ten years, before ergonomic changes were implemented to a great degree," (Ex. 89-15), caused disc weakness and eventually disc herniation. (Ex. 89-15-16).

Drs. Dinneen, Platt, and Smith provide the medical evidence challenging the claim. Drs. Dinneen and Platt related claimant's low back problems to "degenerative changes." (Ex. 72). Because there is no evidence indicating that claimant's degeneration preexisted his employment, and particularly in light of Dr. Browning's opinion that claimant's work *caused* his degeneration, we do not find the examiners' opinions helpful in evaluating causation.[7] Moreover, because the examiners mistakenly believed that claimant performed *no* work activities involving his low back, we also find that their conclusions are based on an inaccurate history. (Ex. 91). Dr. Smith also opined that claimant's L4-5 problem was degenerative, stating that claimant's degeneration was genetic, rather than work related because some people who work hard with their backs do not get early degeneration. (Ex. 93-2). We do not find Dr. Smith's opinion particularly persuasive because it is essentially general, rather than specific to claimant, and it does not effectively rebut Dr. Browning's reasoning. (Ex. 93-2). Accordingly, we conclude that the examiners' opinions cast little doubt on Dr. Browning's specific, thorough conclusions. Accordingly, based on Dr. Browning's' opinion, we conclude that claimant has carried his burden.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). He requests a $5,500 fee for services at hearing and a $2,000 fee for services on review, noting that he has practiced Oregon workers' compensation law for nine years. Claimant's counsel outlines the following actions taken on claimant's behalf at the hearings level as follows: Client meeting and file set up; review of medical records, chart notes and other relevant documents; solicitation of medical information and reports from Dr. Browning; deposition of Dr. Browning; preparation for hearing, including witness preparation and document review; and appearing at the November 4, 1998 hearing. Claimant's counsel also outlines the following actions taken on claimant's behalf on review: Review of 53-page transcript and 104 exhibits; legal research; and outline and draft brief.

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[5] Dr. Ono initially withheld any opinion about the cause of claimant's herniated disc, in the absence of a precipitating event, because he is not "an expert in deciding the causative relationship of the working activities with the lumbar disc herniation except a very obvious case where definite trauma was present. . . ." (Ex. 92-1). *See* n. 6.

[6] Dr. Ono eventually advised Dr. Browning that he would say that claimant's condition is work related if his work activities were more stressful than "common" for 40 year old men, but not if claimant did even more strenuous activities off work. (Ex. 89-14). In our view, Dr. Ono's reasoning supports the claim.

[7] We note that Dr. Ono's surgical finding that "the ligamentum flavum was fairly firmly attached to the dura" probably indicates long-standing degeneration. (Exs. 77-2, 93-1). But this does not help us evaluate causation, because claimant worked for the employer for over 12 years and there is no evidence that any low back condition preceded his employment. Moreover, as we note herein, Dr. Browning attributes claimant's degeneration to his repetitive traumatic work activities.

Our review of the record reveals the following information. The issue in dispute was the compensability of claimant's occupational disease claim for a herniated lumbar disc condition. The employer denied the claim on October 1, 1997. Claimant retained her attorney soon thereafter and the attorney promptly filed a hearing request.

Claimant's counsel generated at least one medical report and participated in a 24-page deposition of Dr. Browning. Five witnesses testified at the hearing on claimant's behalf. Claimant submitted approximately 25 pages of argument on review.

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 a herniated disc condition, with medical evidence forcefully disputing causation). The claim's value and the benefits secured are above average, because claimant required surgery for his compensable condition. 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.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $5,500 is a reasonable attorney fee for services at the hearings level and on review. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's counsel's fee request and appellate briefs), the medical complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated November 23, 1998 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant is awarded a $5,500 attorney fee, payable by the employer.

March 11, 1999 Cite as 51 Van Natta 426 (1999)

In the Matter of the Compensation of
DIANE C. PENN, Claimant
WCB Case Nos. 98-05985 & 98-05865
ORDER OF ABATEMENT
Edward J. Harri, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our February 17, 1999 order that referred to claimant's attorney's "services on review" as the basis for a $750 attorney fee under ORS 656.382(2). The employer contends that the "Order" section of our opinion should be corrected to be consistent with the previous paragraph that awarded an attorney fee of $750 for claimant's attorney's services *at hearing* for successfully defending against the employer's request for reduction of claimant's scheduled permanent disability award.

We have received claimant's response to the employer's request for reconsideration. In order to consider this matter, we withdraw our February 17, 1999 order. The employer is granted an opportunity to respond to claimant's letter. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK F. POINTER, Claimant
Own Motion Case No. 99-0050M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's claim for an alleged worsening of his May 26, 1987 industrial injury. Claimant's aggravation rights expired on July 28, 1992. SAIF has accepted the compensability of, and responsibility for a proposed pain center treatment. SAIF recommends reopening of claimant's claim for the provision of temporary disability benefits.

Under ORS 656.278(1)(a), we may exercise our "Own Motion" authority and reopen a claim for 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.

Accordingly, we have the authority to reopen a claim for pain center treatment requiring *inpatient* hospitalization. *Joseph Fisher*, 45 Van Natta 2112 (1993). We may also reopen a claim for pain center treatment on an *outpatient* basis where overnight accommodation away from home is necessary to obtain maximum benefits from the treatment. *Richard N. Uhing*, 50 Van Natta 1611 (1998). Under such circumstances, pain center treatment is treated as hospitalization. *Lenne Butcher*, 41 Van Natta 2084 (1989).

Here, claimant was referred by his treating physician for a Pain Center Evaluation for his unremitting low back pain. The Pain Center doctors recommended that claimant undergo a three-week multidisciplinary pain management program at their facility. The recommendation does not indicate whether this is an in-patient program. Although there is mention of claimant having to be away from his home for the three-week period, neither the doctors at the pain center nor his attending physician have requested overnight accommodations in order to maximize the benefits from claimant's treatment at the pain center. Thus, the proposed pain center treatment does not satisfy the criteria outlined above. As a result, we are not authorized to grant claimant's request for reopening.

Accordingly, the request for own motion relief is denied.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE I. HARGADINE, Claimant
WCB Case Nos. 98-03667, 98-00442, 98-00054, 98-00443, 97-09098, 98-00463, 98-00896, 98-01016, 98-00464 & 98-02136
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Mannix, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Gilroy Law Firm, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest, on behalf of Total Mechanical (Liberty/Total), requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; (2) upheld Liberty Northwest/Jim's Plumbing's (Liberty/Jim's) denial of claimant's claim for the same condition; and (3) upheld the SAIF Corporation's denial of claimant's claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant, a plumber, worked for Liberty/Jim's from February 3, 1993 through July 8, 1993. In April 1993, claimant was seen by Dr. Miller who noted that claimant reported numbness and tingling in his hands and forearms for the past five years. Claimant filed a claim for bilateral carpal tunnel syndrome. Claimant was seen by Dr. Rosenbaum, who diagnosed mild bilateral carpal tunnel syndrome.

In an October 28, 1993 stipulated settlement, Liberty/Jim's accepted claimant's claim for bilateral carpal tunnel syndrome.

On October 4, 1995, claimant began working for SAIF's insured, Thermal Mechanical. Dr. Rosenbaum indicated on July 12, 1996, that nerve conduction studies showed deterioration on the right, but no worsening from 1993 studies on the left. Dr. Rosenbaum suggested consideration of right carpal tunnel surgery.

Claimant began working for Liberty/Total on April 7, 1997. On January 19, 1998, claimant underwent surgery to treat right carpal tunnel syndrome. Claimant underwent left carpal tunnel surgery on February 9, 1998.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that responsibility was initially assigned to Liberty/Jim's as the carrier with an accepted claim for bilateral carpal tunnel syndrome. The ALJ found, however, that Liberty/Jim's had shifted responsibility forward to Liberty/Total. On review, Liberty/Total argues that Liberty/Jim's remains responsible under ORS 656.308(1). For the following reasons, we agree and reverse.

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 Liberty/Jim's, as the carrier with an accepted claim for bilateral carpal tunnel syndrome, unless the record establishes that claimant sustained a new occupational disease involving the same condition. To establish a new occupational disease, the record must demonstrate that claimant's employment conditions subsequent to his employment with Liberty/Jim's were the major contributing cause of the combined condition and pathological worsening of his disease. ORS 656.802(2)(b); *Pamela T. Smith*, 50 Van Natta 2162 (1998); *Tivis E. Hay*, 48 Van Natta 558, 560 (1996).

After our review of the record, we find Dr. Button's opinion to be well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259 (1986). Thus, we rely on Dr. Button's persuasive opinion. Although he opined that claimant's work subsequent to 1993 pathologically worsened claimant's preexisting condition, Dr. Button also opined that claimant's work up to 1993 represented the major contributing cause of claimant's overall combined condition. Thus, although claimant's work after his employment with Liberty/Jim's pathologically worsened claimant's preexisting

carpal tunnel syndrome condition, the post-1993 employment was not the major contributing cause of the combined condition as required by ORS 656.802(2)(b). Because claimant's work activities subsequent to his employment with Liberty/Jim's were not the major contributing cause of combined condition, Liberty/Jim's has not established that a new compensable occupational disease involving the same condition occurred at a later employment.[1] Thus, pursuant to ORS 656.308(1) responsibility remains with Liberty/Jim's.

Claimant has submitted a respondent's brief and seeks an attorney fee on review pursuant to ORS 656.382(2). However, compensability was not litigated at hearing and there is no evidence that claimant's compensation was at risk of disallowance or reduction. (In fact, based on his 801 claim form with Liberty/Total, claimant's TTD rate will be higher under the Liberty/Jim's claim than it would be under the Liberty/Total claim to which the ALJ had assigned responsibility. (Exs. 39; 54)). Because claimant's compensation was not at risk of disallowance or reduction, claimant's attorney is not entitled to an attorney fee for services on Board review. See ORS 656.382(2); *Vance T. Ferguson*, 50 Van Natta 320 (1998); *John H. Kirkpatrick*, 47 Van Natta 2105 (1995).

ORDER

The ALJ's order dated September 11, 1998 is reversed in part. Liberty/Jim's denial is set aside and the claim remanded to Liberty/Jim's for processing according to law. The denials of SAIF and Liberty/Total are upheld. Liberty/Jim's is responsible for payment of the ALJ's $1,000 attorney fee award. The remainder of the ALJ's order is affirmed.[2]

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[1] We find this case similar to *SAIF v. Britton*, 145 Or App 288 (1996). There, the claimant filed a claim for bilateral carpal tunnel syndrome which was accepted by the first carrier. Subsequently, the claimant was injured in a motor vehicle accident while working for a later employer. The claimant later sought treatment for a worsening of his left carpal tunnel symptoms and both carriers denied responsibility for that condition. The ALJ found the first insurer responsible. On review, we reversed, finding the second employer responsible. We reasoned that, by finding that the motor vehicle accident pathologically worsened the left carpal tunnel syndrome, the claimant's physician established that the motor vehicle accident at the second employment was the major contributing cause of the need for treatment.

The court reversed, finding that our conclusion that the motor vehicle accident pathologically worsened the left carpal tunnel condition fell short of the mark. The court held that the pertinent question was whether the motor vehicle accident constituted the major contributing cause of the claimant's need for treatment of his left carpal tunnel syndrome. The court stated that that inquiry required a comparison of the relative contribution to the claimant's need for treatment of the preexisting left carpal tunnel syndrome and the motor vehicle accident at the second employer.

Here, as in *Britton*, the fact that the subsequent employments pathologically worsened the carpal tunnel syndrome does not address the issue of what constituted the major contributing cause of the combined condition. Based on Dr. Button's opinion, we find that the record does not establish that the employments subsequent to Liberty/Jim's were the major contributing cause of the combined condition. Accordingly, we find that responsibility remains with Liberty/Jim's under ORS 656.308(1).

[2] GAB Robins has submitted a brief arguing that it should be dismissed from the proceedings in this matter. We note that the ALJ dismissed the request for hearing against GAB Robins and the requests for hearing against several other carriers in his order. That portion of the ALJ's order was not contested and is affirmed.

In the Matter of the Compensation of
MARK A. KLOUDA, Claimant
WCB Case No. 97-02961
ORDER OF ABATEMENT
G. Joseph Gorciak III, Claimant Attorney
Reinisch, et al, Defense Attorneys

On February 12, 1999, we reversed that portion of an Administrative Law Judge's (ALJ's) order that awarded a $3,500 insurer-paid attorney fee. Contending that he is entitled to an insurer-paid attorney fee award under ORS 656.382(1) and 656.386(1), claimant seeks reconsideration of our decision.

In order to further consider claimant's request, we withdraw our February 12, 1999 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

March 16, 1999 Cite as 51 Van Natta 430 (1999)

In the Matter of the Compensation of
JAMES A. ANDRADE, Claimant
WCB Case No. 98-04482
ORDER ON REVIEW
Hollander, Lebenbaum, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied his request to continue the hearing for the admission of additional medical evidence from his attending physician; and (2) upheld the self-insured employer's denial of claimant's neck condition. Contending that the ALJ's continuance ruling was erroneous, claimant requests remand for consideration of the attending physician's "post-hearing" medical reports and to allow a deposition of that physician. On review, the issues are continuance (remand) and compensability. We deny claimant's request and affirm.

FINDINGS OF FACT

Claimant has been working for the employer since October 1993. (Tr. 24). His job activities mainly include core laying. (Tr. 25). Claimant explained that his job involved catching wood coming out of the machine with glue on it and throwing it to each side. (*Id.*) He was required to duck out of the way to avoid sheets of veneer going over his head. (Tr. 25, 30).

Claimant testified that he woke up with a sore neck on February 24, 1998. (Tr. 33). After about three hours at work, claimant noticed his arm going numb. (*Id.*) He finished his shift and sought emergency medical treatment the next day. (Tr. 33, 34). On February 25, 1998, Dr. Woods diagnosed claimant with a neck and left shoulder strain and peripheral nerve impingement due to muscle spasm. (Ex. 2-3).

Claimant again sought emergency medical treatment on February 28, 1998 and was treated by Drs. Veldstra and Whitney. Dr. Veldstra reported that claimant had denied any trauma, stating that he had woken up with neck pain. (Ex. 3-2). He diagnosed cervical radiculopathy and referred claimant to Dr. Whitney, who recommended an MRI. (Ex. 3-4). On March 10, 1998, Dr. Whitney reported that claimant had a very large herniation at C6-7 on the left and also appeared to have a herniation at C5-6. (Ex. 5-1).

Claimant signed an "801" form on March 24, 1998. (Ex. 6).

On April 2, 1998, Dr. Bert performed an anterior cervical discectomy and fusion at C5-6 and C6-7. (Ex. 7-4).

The self-insured employer's denial was dated April 6, 1998 and claimant indicated that he received the denial on April 9, 1998. (Ex. 8). Claimant's attorney mailed a request for hearing on June 8, 1998. The "Notice of Hearing" form indicates that claimant's request for hearing was received by the Board on June 8, 1998.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

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

Evidence/Request for Continuance

On August 10, 1998, the employer submitted Exhibits 1 through 12, which were received by the ALJ on August 12, 1998. (Tr. 1, 5). Claimant's attorney said that he assumed he had received the exhibits on the same day. (Tr. 5). Exhibit 11[1] was a letter from Dr. Bert indicating that he concurred with Dr. Whitney's April 7, 1998 chart note (Ex. 9), which had indicated that it was unlikely claimant had an on-the-job injury and his work activities were not the major contributing cause of his herniated discs.

The ALJ's order indicated that, before the hearing, claimant's attorney sought a "postponement" to cross-examine Dr. Bert with respect to his opinion in Exhibit 11. The ALJ explained: "Without obtaining information off the record about the status of the challenged report and the timeliness of the request, I advised the parties they should not expect a problem getting the postponement but that we would consider the postponement request on the record at hearing." (Opinion & Order at 3).

At the September 3, 1998 hearing, claimant's attorney requested that the record be kept open for the cross-examination of Dr. Bert regarding his opinion in Exhibit 11. (Tr. 4). The employer's attorney stated that he first received a request from claimant's attorney to cross-examine Dr. Bert regarding his causation opinion on August 26, 1998. (Tr. 4-5). Claimant's attorney did not dispute that fact. (Tr. 5). The ALJ cited OAR 438-006-0081(5), noting that in order to allow a postponement of a hearing for incomplete case preparation, there must be a finding of due diligence.[2] (Tr. 7). The ALJ found that the document upon which claimant premised the request for a "postponement" (Exhibit 11) had been submitted August 10, 1998, but claimant's request to cross-examine Dr. Bert was not made within 7 days, pursuant to OAR 438-006-0081(5). (Tr. 7; Opinion & Order at 7-9). Consequently, the ALJ denied claimant's request for a continuance.

After claimant's attorney protested the ALJ's ruling, the employer's attorney withdrew Exhibit 11 in order to end the controversy. (Tr. 8). Claimant's attorney responded:

> "That doesn't undo the fix. The problem, there, Judge, is based on my understanding that there was -- wasn't an opposition to my request for cross-examination, I did mail Dr. Bert a request for information on the 27th. And I asked him to back -- get it back to me promptly.
>
> "I did not follow it up saying, 'Look, Doctor, I need it today. I need it today. I need it today, because we're going to hearing,' based on my assumption that it was unopposed. That their document was going to be submitted into the record." (Tr. 8).

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[1] We note that proposed Exhibit 11 was withdrawn by the employer at hearing.

[2] Under OAR 438-006-0091(4), a continuance may be granted for any reason that would justify postponement of a scheduled hearing under OAR 438-006-0081. OAR 438-006-0081(5) (WCB Admin. Order 1-1997) provides, in 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. "Extraordinary circumstances" shall not include:
>
> "* * * * *
>
> "(4) Incomplete case preparation, unless the Administrative Law Judge finds that completion of the record could not be accomplished with due diligence. A subpoena of a medical expert witness is not required to satisfy due diligence.
>
> "(5) For purposes of this rule, 'due diligence' shall include, but not be limited to, the unavailability of a medical or vocational expert witness for cross-examination by deposition/interrogatories prior to a scheduled hearing, provided that the request for cross-examination was made no later than seven (7) days after the requesting party received from another party a copy of a report from the medical or vocational expert witness accompanied by written notice that the sending party is submitting the report as a proposed exhibit for admission into evidence at a scheduled hearing."

At the conclusion of testimony, claimant's attorney again requested that the record be left open for the cross-examination of Dr. Bert or to allow him to respond to the August 27, 1998 letter. (Tr. 82). The ALJ did not change his ruling. After the hearing, claimant's attorney submitted Exhibits 14 and 15, which consisted of claimant's August 27, 1998 letter to Dr. Bert and his response. The ALJ declined to reopen the record, reasoning this was "the very documentation that claimant sought the postponement to obtain." (Opinion & Order at 9; footnote omitted).

On review, claimant argues that the ALJ erred in denying his request to continue the hearing when the ALJ had previously advised the parties they should not expect a problem obtaining a postponement. Claimant asserts that the "extraordinary circumstances" justifying a continuance was the ALJ's changing his "ruling" to not allow a continuance. Claimant contends that his attorney relied on the ALJ's pre-hearing statements to his detriment and did not pursue Dr. Bert's immediate response to the August 27, 1998 letter.

For the following reasons, we need not address the interpretation of OAR 438-006-0081(5). We agree with the employer that, even if we assume that claimant has shown "extraordinary circumstances" and "due diligence" necessary to continue or postpone the hearing, there is no medical opinion for claimant to rebut, because the employer withdrew Exhibit 11 at hearing. Claimant's attorney had requested that the record be kept open for the cross-examination of Dr. Bert regarding his opinion in Exhibit 11. (Tr. 4). The employer subsequently withdrew Exhibit 11, thereby extinguishing the basis for cross-examining Dr. Bert. *See Robert Rappin*, 46 Van Natta 313 (1994) (the carrier's withdrawal of the exhibit extinguished the basis for the deposition; a continuance was not necessary for the claimant to obtain final rebuttal evidence). Because Exhibit 11 was withdrawn by the employer, we need not address the propriety of the ALJ's ruling on claimant's request for a continuance.

Furthermore, we note that, even if we were to conclude that Exhibits 14 and 15 should be admitted in evidence, the proffered exhibits would not affect the outcome of this case. In other words, Exhibits 14 and 15 are not sufficient to establish that claimant's work activities were the major contributing cause of his C5-6 and C6-7 herniated discs.

Compensability

We adopt and affirm the ALJ's reasoning and conclusion that claimant has failed to establish compensability of the C5-6 and C6-7 herniated discs, with the following change. At the end of the third paragraph on page 10, we change the citations to read: "(Exs. 9, 10, 12)."

ORDER

The ALJ's order dated October 9, 1998 is affirmed.

March 16, 1999 Cite as 51 Van Natta 432 (1999)

In the Matter of the Compensation of
JANIS L. ARMSTRONG, Claimant
WCB Case No. 98-05428
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the SAIF Corporation's denial of claimant's injury or occupational disease claim for an upper body condition. On review, the issue is compensability.

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

Claimant has a long history of recurring upper body problems. She had accepted claims for a thoracic strain and left carpal tunnel syndrome in 1993. (Exs. 8, 11). Right lateral epicondylitis was diagnosed in 1994 and claimant had physical therapy for neck, thoracic, shoulder, and wrist symptoms. (Ex. 12). Her symptoms continued intermittently and claimant filed a claim for bilateral hand pain that

radiated to her shoulders in 1996. (Exs. 14, 15, 17-2). The 1996 claim was denied and claimant's subsequent request for hearing was dismissed. (Exs. 18, 20). Claimant's variable bilateral upper body symptomatology continued through 1997. (Ex. 28-2). She sought treatment for upper body problems in December 1997, (*see* Ex. 22-1), and filed a claim for right upper back shoulder, arm, and hand symptoms on March 30, 1998. (Exs. 21, 23).

The current dispute involves an allegedly "distinct situation," related to 2-5 days of intensive repetitive work activities. (Exs. 21, 22-1, 28-2, *see* Exs. 20A, 29A; Tr. 2). We need not determine whether the claim is properly analyzed as an injury or a disease, because we agree with the ALJ that Dr. Flaming's opinion is not persuasive.

Dr. Flaming, osteopath, provides the medical evidence supporting the claim. (Ex. 29A). He acknowledged that claimant had "some similar problems in the past, [but] they tend to resolve. . . ." (*Id*). Based on claimant's history, Dr. Flaming opined that the current problems are a "distinct situation though it is somewhat clouded by similar problems in the past." (*Id*). Dr. Flaming did not otherwise address claimant's long history of recurring upper body problems. Considering the long-standing and ongoing nature of the prior problems, we cannot say that Dr. Flaming's opinion is adequately reasoned. *See e.g., Richard R. Rinehart*, 51 Van Natta 173, 174 (1999) (Physician's opinion unpersuasive because based in part on an incorrect belief that the claimant's prior similar problems resolved rapidly and completely). Consequently, we decline to rely on Dr. Flaming's opinion and therefore conclude that claimant has not carried her burden of proof.

ORDER

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

March 16, 1999 Cite as 51 Van Natta 433 (1999)

In the Matter of the Compensation of
WILLIAM D. STEWART, Claimant
WCB Case No. 98-04284
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) awarded 19 percent (28.5 degrees) scheduled permanent disability for loss of use or function of the right leg, whereas an Order on Reconsideration awarded no scheduled permanent disability; and (2) increased claimant's unscheduled permanent disability for his low back and right hip from 20 percent (64 degrees), as awarded by an Order on Reconsideration, to 41 percent (131.2 degrees). On review, the issue is extent of scheduled and unscheduled permanent disability.

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

Claimant compensably injured his right hip on March 4, 1996. The insurer initially accepted a right hip sprain and later amended the acceptance to include a "right closed" ilium fracture. (Exs. 5, 9, 13). As a result of a stipulated order, the insurer agreed to accept a right hip avulsion fracture and myofascial pain syndrome of the right hip, low back, buttock and thigh. (Exs. 37, 38).

A July 26, 1996 Determination Order did not award any permanent disability. (Ex. 14). A December 10, 1996 Order on Reconsideration awarded claimant 20 percent (64 degrees) unscheduled permanent disability for his right hip. (Ex. 22). A December 23, 1997 Determination Order did not award any additional permanent disability. (Ex. 39). Claimant requested reconsideration. (Ex. 40). Dr. Staver performed a medical arbiter examination. (Ex. 43). A May 14, 1998 Order on Reconsideration affirmed the December 23, 1997 Determination Order. (Ex. 45).

Claimant requested a hearing. The ALJ relied on the medical arbiter's examination and increased claimant's unscheduled permanent disability for his low back and right hip from 20 percent to 41 percent (131.2 degrees) and also awarded 19 percent scheduled permanent disability for loss of use or function of the right leg.

On review, the insurer argues that claimant received a permanent disability award in 1996 and that award assumes and covers fluctuation of symptoms. According to the insurer, ORS 656.214(7) takes into account the periodic waxing and waning of symptoms.

The insurer is correct that claimant received an unscheduled permanent disability award (20 percent) for his right hip on December 10, 1996. (Ex. 22). At that time, however, only claimant's right hip strain and right closed ilium fracture had been accepted. On December 9, 1997, the insurer accepted a right hip avulsion fracture and myofascial pain syndrome of the right hip, low back, buttock and thigh. (Ex. 38). The claim was again closed by a Determination Order on December 23, 1997. (Ex. 39). To the extent that the insurer is arguing that claimant's permanent disability award in 1996 was intended to compensate him for the subsequent "post-closure" accepted conditions, we are not persuaded.

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), ORS 656.268(7)(a) and ORS 656.268(7)(b); OAR 436-035-0007(12) and (13) (WCD Admin. Order 96-072). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(13). This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. *See Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). We 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).

The insurer contends that the arbiter's findings do not meet the validity requirements of OAR 436-035-0007(27),[1] which provides that a physician's determination that impairment findings are invalid must include a "written opinion, based on sound medical principles, explaining why the findings are invalid." Otherwise, all ratable impairment shall be rated. *See Justeen L. Parker*, 49 Van Natta 334 (1997) (arbiter's range of motion measurements were rated because the arbiter did not identify the validity standards that were not satisfied, nor did he provide a written explanation of why the range of motion measurements did not meet validity standards).

Here, Dr. Staver performed a medical arbiter examination on April 24, 1998. He reported that claimant was unable to sleep on his right hip and he was unable to sit with his hip flexed without creating pain in his leg and back. (Ex. 43-1). Claimant had noticed increasing pain with snapping in his hip and listed his pain as 9 on a scale of 10. (*Id.*) Dr. Staver reported 4/5 strength in the right hip flexors, quadriceps and hamstrings, decreased sensation in the plantar aspect of claimant's right foot, as well as decreased range of motion in the right hip and lumbar spine. (Ex. 43-2). Dr. Staver explained:

> "[Claimant] does have a loss of ability to repetitively use the areas involved due to a permanent medical condition, namely the avulsion fracture in the vicinity of the right hip. It is my concern in reviewing his medical records that there has been significant change in his range of motion of the hip and the lumbar spine when comparing this to an evaluation as recent as June 24, 1997, where according to the examiners at that time it was noted that the range of motion of the lumbar spine was 'full range and pain free.' Also, the range of motion of the right hip at that time was much better than it is at this point and this raises my concern that my findings are inappropriate to consider as part of an arbitration process and would indicate to me that there is potential that there may be some active process that is worsening the status of his hip." (Exs. 43-2, -3).

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[1] OAR 436-035-0007(27) provides:

"Validity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990**, unless the validity criterion for a particular finding is not addressed in this reference, is not pertinent to these rules, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid. When findings are determined invalid, the findings shall receive a value of zero. If the validity crieterion are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid. " (Bold in original).

Dr. Staver's conclusion was "after performing this examination and comparing it with previous studies is that there has been significant change which would indicate these findings today are invalid." (Exs. 43-3). He felt that claimant was able to lift and carry in the light/medium category, but was restricted from crawling, squatting, crouching and climbing on a frequent basis. (*Id.*)

Based on Dr. Staver's report of a "significant change" in claimant's condition, the Appellate Unit asked the parties if they would consent to postponement of the reconsideration proceeding until claimant's condition had medically resolved. (Ex. 45-1); *see* OAR 436-030-0165(6) (WCD Admin. Order 96-052). The insurer did not agree to a postponement and the Appellate Unit proceeded with reconsideration. (Ex. 45-2).

The insurer argues that Dr. Staver adequately explained why the findings were invalid as required in OAR 436-035-007(27). Although Dr. Staver provided a written opinion that attempted to explain why the findings are invalid, we are not persuaded that Dr. Staver's opinion as to the "invalidity" was well-reasoned or based on sound medical principles.

Dr. Staver felt there was "potential that there may be some active process that is worsening the status of [claimant's] hip." (Exs. 43-3). His opinion suggests a possibility of a worsening in claimant's hip condition, but his opinion is not stated in terms of reasonable medical probability. *See Crystal L. Dougherty*, 49 Van Natta 1485 (arbiters did not determine, within reasonable medical probability, that the lumbar range of motion measurements were invalid), *corrected* 49 Van Natta 1560 (1997). Furthermore, Dr. Staver did not state that claimant's condition was not medically stationary at the time of his examination. *Compare James C. Risener*, 50 Van Natta 181 (1998) (medical arbiter's impairment findings were not persuasive because the arbiter concluded that the claimant's condition was not medically stationary and, in addition, the claimant had established a compensable aggravation claim).

Dr. Staver made no mention as to any functional behavior on claimant's part and did not refer to the fact that any of the measurements or findings were inconsistent with validity tests. In other words, Dr. Staver did not indicate that any of the findings, in and of themselves, were invalid. Rather, he opined that, because there had been a significant change since the previous studies, the current findings were invalid. (Ex. 43-3). Dr. Staver did not explain why a different result meant that the current findings were invalid. Because Dr. Staver's opinion is not well-reasoned, we find that his explanation of invalidity was not based on sound medical principles, particularly in light of Dr. Grant's May 6, 1998 report.

On May 6, 1998, Dr. Grant, claimant's attending physician, commented on Dr. Staver's report and said that claimant would have "waxing and waning" with regard to his myofascial hip and low back problems and his chronic hip strain problems. (Ex. 44). He had previously examined claimant on March 9, 1998. (Ex. 41). Dr. Grant felt that Dr. Staver had examined claimant on a "bad day," whereas he and Drs. Duff and Wilson had examined claimant on "good days" with regard to his ranges of motion. (*Id.*) Dr. Grant explained:

> "Keeping all of the above in mind, I feel it would be best to close [claimant's] claim based on the findings of Dr. Staver's 4/24/98 medical arbiter examination. This is the most recent/current examination and it evaluates his most significant problems objectively." (*Id.*)

Dr. Grant's report indicates he did not believe claimant had a significant change in his condition. Rather, Dr. Grant's report demonstrates that claimant's findings were within the range of "waxing and waning" anticipated at closure. Dr. Grant did not indicate that the claim had been prematurely closed or that claimant's condition was not medically stationary. Instead, Dr. Grant believed that claimant's impairment should be based on Dr. Staver's findings. Based on Dr. Grant's report, we agree with the ALJ's reliance on Dr. Staver's examination findings in rating claimant's permanent disability.

The insurer also argues that the ALJ incorrectly calculated the unscheduled adaptability rating. According to the insurer, the correct value for the residual functional capacity is "4," rather than "5," as found by the ALJ. We disagree.

Dr. Staver reported that claimant was able to lift and carry in the "light/medium" category. (Ex. 43-3). He also found that claimant was restricted as far as crawling, squatting, crouching and climbing on a frequent basis. (*Id.*)

A comparison of claimant's base functional capacity (heavy) to his residual functional capacity (RFC) of light/medium would provide a value of "4" for adaptability. *See* OAR 436-035-0310(6). However, OAR 436-035-0310(7) provides that for workers determined by these rules to have a RFC established between the two categories and also have restrictions, the next lower classification shall be used. Because claimant's RFC (light/medium) is between two categories and he also has restrictions, the next lower classification will be used, which provides a value of "5" for adaptability. *See* OAR 436-035-0310(6). We agree with the ALJ that the correct value for the residual functional capacity is "5."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 23, 1998, as amended on October 30, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
WALTER H. MAGBY, Claimant
WCB Case Nos. 98-07913 & 98-06645
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) found that claimant had not perfected a timely aggravation claim regarding his 1993 low back injury with the SAIF Corporation; (2) declined to award a penalty for SAIF's alleged failure to process the aggravation claim; (3) upheld SAIF's responsibility denial of his "new injury" claim for his current low back condition; (4) awarded interim compensation in relation to the 1998 claim; and (5) assessed a penalty for untimely payment of interim compensation. On review, the issues are jurisdiction, responsibility, interim compensation, and penalties. We affirm.

FINDINGS OF FACT

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

Claimant worked for the employer, an underground utility construction group, performing general labor, including shoveling, digging ditches and driving vehicles. On April 30, 1993, claimant was lifting at work and felt sudden pain in his low back without radiculopathy. X-rays were negative and Dr. Gooch, claimant's family physician, diagnosed a back strain. SAIF accepted a disabling lumbosacral strain. On May 21, 1993, Gooch released claimant to regular work. The claim was closed by a July 23, 1993 Notice of Closure that awarded temporary disability only.

After his May 1993 closing examination, claimant did not seek medical treatment for back symptoms until March 1998. However, he experienced intermittent discomfort which he self-treated with over-the-counter anti-inflammatories.

On March 23, 1998, he sought treatment with Dr. Gooch for low back pain without radiculopathy. At this time, claimant was unable to walk. Gooch diagnosed a severe low back strain with sacroiliac involvement and referred claimant to Dr. Hubbard for evaluation.

On March 25, 1998, claimant filed a new injury claim with the employer, noting that he had had a prior injury to his low back. On March 30, 1998, Dr. Gooch released him to restricted work.

Dr. Hubbard examined claimant on April 9, 1998. X-rays revealed mild narrowing of the L5-S1 interspace and a March 25, 1998 MRI showed a partial degenerative disc signal at L4-5 and a degenerative disc at L5-S1 with a central and right sided small focal disc protrusion or herniation at the lumbosacral junction. Hubbard diagnosed chronic intermittent low back pain by history, consistent with a muscle strain pattern. He was unable to ascertain whether the central disc at L5-S1 was contributing to the process, noting that it was unknown when the disc abnormality occurred. He also remarked that claimant's low back symptoms arose gradually, rather than a sudden onset consistent with disc problems.

On April 3, 1998, Dr. Gooch submitted an aggravation form to SAIF along with a chart note dated March 30, 1998. The form included the claim number for the 1998 claim but no date of injury, and the chart note did not discuss causation.

On June 16, 1998, Dr. Gooch noted that claimant's symptoms had resolved and released him to regular work.

On June 22, 1998, SAIF issued a responsibility denial for the 1998 claim, stating that claimant's condition was the responsibility of another employer and/or insurer.

Sometime later, Dr. Gooch's office submitted a corrected aggravation claim identifying the correct claim number and date of injury. Although the claim form was accompanied by chart notes, it was not accompanied by an attending physician's report establishing that claimant's worsened condition was attributable to the compensable 1993 injury, nor was such a report received by SAIF on or before July 23, 1998, the date claimant's aggravation rights expired.

On October 6, 1998, Dr. Gooch provided a letter to claimant's attorney that attributed the major contributing cause of claimant's need for treatment and disability for the current low back condition to the March 23, 1998 work injury.

On August 20, 1998, as amended October 2, 1998, claimant filed a request for hearing on SAIF's responsibility denial and raised the issue of a "de facto" aggravation denial.

CONCLUSIONS OF LAW AND OPINION

Aggravation/Penalty for Failure to Process Claim

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

The filing requirements of ORS 656.273 are jurisdictional. *SM Motor Co. v. Mather*, 117 Or App 176 (1992); *Timothy D. Beard*, 43 Van Natta 432 (1991). A claim for additional compensation made outside the time limits of ORS 656.273 falls within the Board's own motion jurisdiction. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988); *Edward R. Reuter*, 42 Van Natta 19 (1990).

A claim for aggravation must be filed within five years after the first determination or the first notice of closure. ORS 656.273(4)(a). The claim must be in writing in a form and format prescribed by the director and signed by the worker (or the worker's representative) and must be accompanied by an attending physician's report which establishes that the claimant has suffered a worsened condition attributable to the compensable injury. ORS 656.273(3). The two essential elements for a "claim for aggravation" are the completed Director's form and the accompanying attending physician's report. The timely filing of one without the other does not satisfy the filing requirement of ORS 656.273(4). *David L. Dylan*, 50 Van Natta 276, *on recon*, 50 Van Natta 852 (1998). Therefore, we affirm the ALJ's conclusion that claimant failed to timely perfect a valid claim for aggravation. Consequently, neither we nor the ALJ are authorized to consider the merits of the "aggravation" issue.

Responsibility

The ALJ concluded that SAIF remained responsible for claimant's current low back strain injury under ORS 656.308(1), finding that claimant had not experienced a new injury in 1998. We affirm, with the following supplementation.

After reviewing the record, we agree with the ALJ's finding that claimant's current low back condition is the same condition as his 1993 accepted low back strain condition. Thus, under ORS 656.308(1), SAIF remains responsible for future compensable medical services and disability relating to the 1993 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).

The pertinent question here is whether the lifting injury claimant sustained in 1998 constitutes the major contributing cause of his current need for treatment for his low back. That inquiry requires a comparison of the relative contribution to his need for treatment of his preexisting low back strain and the 1998 lifting injury. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (1995).

Dr. Gooch, claimant's attending physician, provided the only opinion regarding causation, opining that claimant's 1998 lifting injury was the major contributing cause of his current low back condition and need for treatment. For the following reasons, we do not find his opinion persuasive.

After claimant's compensable 1993 low back injury, Dr. Gooch opined that claimant's back symptoms had resolved and he released him to unrestricted work. SAIF closed the claim with no award of permanent disability. Although claimant did not seek medical treatment between the 1993 claim closure and 1998, the evidence indicates that he experienced intermittent discomfort which he self-treated with over-the-counter anti-inflammatories.

On October 6, 1998, Dr. Gooch reported that claimant had experienced an "acute low back strain injury at work" in March 1998. He felt that claimant's recent injury was the major contributing cause of his current need for treatment, explaining that, although claimant has a history of chronic intermittent low back strain that had been going on for many years, he had been fully employed and functioning since Gooch last saw him five years earlier.

We are not, however, persuaded by Dr. Gooch's opinion. Gooch was in possession of Dr. Hubbard's report that discussed the degenerative findings in claimant's low back. However, although Gooch evaluated the contribution of claimant's preexisting chronic low back strain, he failed to discuss the possible contribution of the degenerative discs at L4-5 and L5-S1. Because determination of the "major contributing cause" involves evaluating different causes of an injury or disease (including the diagnosed degenerative condition), *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995), we conclude that Gooch's opinion is insufficient to establish that the 1998 lifting injury was the major contributing cause of claimant's current low back condition. Therefore, we conclude that the evidence is insufficient to establish that claimant experienced a "new" low back injury in 1998.

Interim Compensation and Penalties for Failure to Pay

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

ORDER

The ALJ's December 16, 1998 order is affirmed.

In the Matter of the Compensation of
ROSE M. ACOSTA, Claimant
WCB Case No. 98-01893
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Miller, Nash, 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 set aside its denial of claimant's occupational disease claim for a right wrist and elbow tendonitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant worked on circuit boards for the employer beginning in May 1997. In November 1997, she developed a gradual onset of right upper extremity symptoms. Claimant sought treatment first with Dr. Pierson, then with Dr. Flemmer.

The employer denied claimant's claim, asserting that there was no "objective evidence" of injury. Claimant requested a hearing.

The ALJ found claimant's right wrist and elbow tendonitis condition compensable. He reasoned that Dr. Pierson's recording of claimant's tenderness complaints constituted reproducible objective findings supporting the claim. The ALJ also mentioned swelling as an objective finding and concluded that the claim was compensable, based on Dr. Flemmer's causation opinion and Dr. Pierson's tenderness findings.

On review, the employer contends that the claim should fail for lack of "objective findings."[1] We agree.

Claimant must prove her occupational disease claim with medical evidence supported by objective findings. ORS 656.802(2)(d).

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."

A physician's indication that the worker experiences pain, standing alone, is insufficient to constitute "objective findings." *See Jairo J. Garcia*, 48 Van Natta 235 (1996). But a physician's interpretation of a worker's verifiable subjective response to clinical testing *may* be sufficient, provided it was "reproducible, measurable or observable." *Tony C. Houck*, 48 Van Natta 2443, 2448-49 (1996), *aff'd mem* 151 Or App 200 (1997). Meeting any one of the latter three requirements satisfies the statute. *Id.* at 2449.

Here, claimant reported symptoms to Dr. Pierson and the doctor recorded them. But Dr. Pierson also stated that claimant's pain was "not consistent" at one examination and "really inconsistent" at the other. (Exs. 3-1, 5). He concluded that claimant's first examination was "normal" and there was "no objective evidence of a condition" as of the second examination. (*Id*). We cannot say that claimant's inconsistent subjective reporting to Dr. Pierson amounts to observable, measurable, or reproducible "findings." (*See* Ex. 8).

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[1] We do not reach the employer's contention that Dr. Flemmer's opinion is insufficient to establish "major causation."

Dr. Flemmer examined claimant and reported her symptoms on two occasions. (Ex. 7A, 7C). But nothing about Dr. Flemmer's chartnotes or her opinion suggests that the doctor did more than record claimant's reported symptoms or that those symptoms were reproducible, measurable or observable. Finally, we note that neither doctor recorded physical findings associated with claimant's complaints.[2]

Accordingly, 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. *See Linda S. Clemens*, 50 Van Natta 2269 (1998); *Anthony D. Sherman*, 49 Van Natta 1258 (1997). It follows that claimant's injury claim is not compensable.

ORDER

The ALJ's order dated December 1, 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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[2] Claimant's physical therapist once recorded claimant's reporting that she had swelling at her right dorsal web space at the "end of day." (Ex. 4). But we find claimant's reporting to the therapist insufficient to constitute medical evidence supported by objective findings, because examining physicians repeatedly found no swelling and claimant's subjective reporting is described as inconsistent. *See Linda S. Clemens*, 50 Van Natta 2269, 2270, n.1 (1998). In addition, although Dr. Pierson once noted a "slight nodule along the radial aspect" of claimant's right wrist, he did not relate it to claimant's symptoms or her work. (Ex. 5).

In the Matter of the Compensation of
GERALD K. BURLAGE, Claimant
WCB Case No. 98-04988
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the SAIF Corporation's denial of his right ear injury claim. On review, the issue is compensability.

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

In his brief, claimant argues that Dr. Hodgson's opinion should not be considered as evidence and he asserts that the ALJ erred in considering the "illogical, contradictory, uncooperative report" of Dr. Hodgson.

The ALJ concluded that Dr. Hodgson's opinion was not sufficient to establish that claimant sustained an injury to his right ear as a result of the March 23, 1998 work exposure. The ALJ also commented that, even if Dr. Hodgson's opinion was ignored, the result would not change because there was no medical evidence in the record that objectively established that claimant sustained a right ear injury at work.

After reviewing the record, we agree with the ALJ's reasoning and conclusion. We need not address claimant's evidentiary argument regarding Dr. Hodgson's opinion because, even if we disregard his opinion, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused his discretion by admitting Dr. Hodgson's opinion. *See Mario F. Torres*, 49 Van Natta 2074 (1997); *Larry D. Poor*, 46 Van Natta 2451 (1994).

We note that this case requires an expert medical opinion to determine causation. In *Barnett v. SAIF*, 122 Or App 279, 283 (1993), the court held that factors for determining whether expert evidence of causation is required include: (1) whether the situation is complicated; (2) whether symptoms appear

immediately; (3) whether the worker promptly reports the occurrence to a superior; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, although claimant testified that his right ear injury occurred on March 23, 1998, he did not seek medical treatment until April 27, 1998. (Ex. 4). There was more than one potential causal factor for claimant's right ear condition, including aging and wax impaction. Furthermore, Dr. Hodgson reported that claimant's need for treatment was not materially related to the March 23, 1998 work exposure. (Ex. 8). Under the circumstances, we conclude that an expert medical opinion is necessary to determine whether claimant's right ear condition is compensable. We agree with the ALJ's conclusion that there is no medical evidence in the record that objectively establishes that claimant sustained a right ear injury at work. We adopt and affirm the ALJ's reasoning and conclusion that claimant has failed to establish compensability of his right ear injury claim.

On review, claimant also contends that SAIF has refused to obey an interim order from a previous ALJ in this case that allegedly directed SAIF to pay claimant $31.50.

Before the hearing, claimant had filed a motion requesting that SAIF pay for a visit to his doctor's office to obtain a note stating that attending an independent medical examination in Eugene would be detrimental to claimant's low back condition. (Ex. 28). A previous ALJ issued an Interim Order on September 3, 1998, concluding that SAIF should pay for claimant's doctor's visit or, in the alternative, SAIF should reschedule the examination in the Portland area. (*Id.*) After SAIF objected to the Interim Order (Ex. 9), that ALJ issued an Interim Order on October 5, 1998 clarifying the earlier order. (Ex. 10A). The ALJ explained:

> "[T]he order clearly states 'if SAIF does not elect to bear the expense of obtaining the note from the claimant's doctor, SAIF should reschedule the IME in the Portland area'; in other words, SAIF is only obligated to bear the expense of obtaining the note from the claimant's doctor if SAIF elects to insist that claimant travel from Portland to Eugene for an IME." (*Id*; emphasis in original.)

We find no evidence in the record that SAIF required claimant to travel to Eugene for an independent medical examination. Under these circumstances, SAIF is not obligated to pay for claimant's visit to his doctor's office to obtain a note stating that attending an independent medical examination in Eugene would be detrimental to his low back condition.

Claimant also argues that SAIF deserves a "severe reprimand" for sending a "false, misleading and libelous letter" to the previous ALJ in this case. To the extent that claimant is contending that he is entitled to a penalty for SAIF's alleged conduct, we disagree with that contention. Because claimant's right ear condition is not compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support an award of a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). Accordingly, claimant is not entitled to a penalty.

ORDER

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

In the Matter of the Compensation of
WAYNE J. LAND, Claimant
WCB Case No. 97-07270
ORDER ON REVIEW
Rose, Senders & Bovarnick, Claimant Attorneys
Wallace Klor & Mann, Defense Attorneys

Reviewed by Board Members Moller and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of his injury claim for a low back condition (L4-5 disc herniation). Claimant also challenges the ALJ's decision to exclude Exhibit 100. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

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

Claimant, age 57 at the time of hearing, worked for the employer as a railroad car repairman. His job duties involved working on condensing units, refrigerants, electrical components and diesel engines.

Claimant has a history of low back discomfort and intermittent chiropractic and medical treatment for that discomfort dating back to the mid-1980s. In September 1996, claimant developed back pain with radiating pain down the right leg while sleeping. A CT scan of the lumbar spine showed a disc herniation at L4-5 and moderate degenerative changes at L5-S1. A December 1996 MRI scan confirmed the disc herniation at L4-5.

In February 1997, claimant underwent back surgery. Dr. Gehling performed an interlaminar decompression with discectomy at L4-5, noting that claimant had a paramedian and subligamentous disc herniation compressing the L4 and 5 root.

In late April 1997, the employer determined that claimant was not medically cleared to return to his regular work duties, and advised claimant that he needed to provide medical information relating to his ability to function safely at work. Claimant was directed to obtain functional information from a PCE (physical capacities evaluation) or work-conditioning program.

On May 13, 1997, claimant saw Dr. Gehling, who determined that he was medically stationary. The doctor wanted to await the PCE findings prior to preparing a final report and releasing claimant to work.

The employer arranged and paid for a PCE examination, which occurred on May 20, 1997. The employer also provided the physical capacities evaluator with a job analysis and the lifting requirements for claimant's job. Claimant did not report any discomfort during the evaluation. The evaluator determined, among other things, that claimant demonstrated a maximum lifting ability of 105 pounds, with floor-to-knuckle and 12''-to-knuckle tasks. Although claimant may have been able to lift more than 105 pounds, the evaluator did not pursue further testing because of safety issues. The evaluator also noted that claimant required education on proper lifting mechanics and that he demonstrated minimal lumbar flexion with higher level lifting tasks.

On May 29, 1997, Dr. Gehling reported that, based on the PCE findings, claimant was medically stationary and capable of returning to his regular work without restrictions.

Meanwhile, a few days after the PCE, claimant experienced a recurrence of back pain and radiating right leg symptoms. He sought treatment on June 5, 1997. An MRI of the lumbar spine revealed a severe recurrent disc herniation at L4-5, primarily on the right side extending into the right lateral recess. On June 12, 1997, claimant reported to Dr. Gehling his belief that the PCE caused his recurrent disc herniation.

On June 16, 1997, Dr. Gehling performed a repeat microhemilaminectomy and discectomy at L4-5 on the right.

Claimant filed a claim for his recurrent disc herniation. He was evaluated by Dr. Rosenbaum at the employer's request on July 31, 1997. Dr. Rosenbaum opined that the recurrent disc herniation was probably a spontaneous event, not caused in any significant part by the PCE. On August 26, 1997, the employer's processing agent denied that claimant's employment was the major cause of his current low back condition. Claimant requested a hearing.

In October 1997, claimant was evaluated by Dr. Smith, a neurosurgeon, on referral from his attorney. On January 26, 1998, claimant was examined by a panel of physicians at the employer's request, including Dr. White, also a neurosurgeon.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

On review, claimant contends that the ALJ erred in excluding Exhibit 100, a supplemental report from Dr. Gehling offered by claimant on the second day of hearing. We disagree.

The record establishes that, on the first day of hearing, the parties set out parameters of the evidence to be presented at the continued hearing. At that time, claimant's attorney did not request that the record be left open for a rebuttal report or cross-examination of Dr. Gehling. Consequently, when claimant offered a supplemental report from Dr. Gehling at the second hearing, the ALJ found that Exhibit 100 fell outside the purpose for which the record had been left open.[1]

We review the ALJ's evidentiary ruling for abuse of discretion. *See James D. Brusseau II*, 43 Van Natta 541 (1991). Here, we find no abuse of discretion in the ALJ's decision to exclude Exhibit 100. We agree with the ALJ that claimant did not, at the first day of hearing, preserve his right to obtain a rebuttal report from Dr. Gehling, and therefore Exhibit 100 fell outside the scope of evidence expected to be presented at the continued hearing. *See Clifford L. Conradi*, 46 Van Natta 854 (1994); *Darrel L. Hunt*, 44 Van Natta 2582 (1992) (When an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose).

Compensability

The ALJ concluded that, even assuming the PCE played a role in claimant's recurrent disc herniation, the injury did not arise out of or occur in the course of claimant's employment. Alternatively, the ALJ found that even assuming the PCE occurred within the course and scope of claimant's employment, claimant did not establish by a preponderance of the evidence that the PCE was the major contributing cause of his disability or need for treatment.

On review, we need not address claimant's contention that his recurrent disc herniation arose out of and occurred in the course of his employment because, even if it did, we are not persuaded that the alleged injury during the PCE is the major contributing cause of his disability or need for treatment thereafter. In this regard, we rely on the opinions of Drs. Rosenbaum and White, who testified that, even assuming claimant's exertions during the PCE contributed to his recurrent disc herniation, the major contributing cause of the recurrence remains his preexisting back condition, particularly the already weakened and torn annulus. (Ex. 95, Tr. 116-20, Tr. 155-59).

We also note that, although Dr. Smith related claimant's reherniation to his lifting more that 100 pounds during the PCE, he did not explain why the lifting activity would be more of a cause than claimant's preexisting degenerative disc disease and weakened annulus.[2] At best, Dr. Smith's opinion establishes only that claimant's exertion during the PCE precipitated the reherniation; it is not, however,

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[1] The ALJ declined to consider Exhibit 100 on the issue of causation, but admitted the report for the limited purpose of indicating what materials Dr. Smith had relied upon in formulating his opinion.

[2] Dr. Smith agreed that claimant would not have experienced a recurrent disc herniation but for his prior annular tear, herniation and surgery.

persuasive evidence that the PCE was the major cause. Consequently, on this record, we agree with the ALJ that claimant has not sustained his burden of proof on medical causation. *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).

ORDER

The ALJ's order dated August 21, 1998, as amended September 3, 1998, is affirmed.

March 18, 1999 Cite as 51 Van Natta 444 (1999)

In the Matter of the Compensation of
JOHN B. McGURN, Claimant
WCB Case No. 97-05339
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's neck and back injury claim; and (2) assessed a $3,000 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand on the attorney fee issue. On review, the issues are compensability, remand and attorney fees.

We deny SAIF's motion for remand, and adopt and affirm the ALJ's order with the following supplementation on the attorney fee issue.

SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in OAR 438-015-0010(4), and that his explanation for the attorney fee award is insufficient. Contrary to SAIF's contention, we find that the ALJ applied the proper standard in determining the assessed fee for services at hearing. The ALJ cited to the applicable rule and identified the factors he considered in determining the attorney fee.[1] *See Daryl L. Underwood,* 50 Van Natta 2330 (1998) (where there is no specific attorney fee requested and the parties do not submit arguments at hearing addressing the factors to be weighed in determining a reasonable fee, the ALJ satisfied his or her obligation to make findings in a case by including a brief description or citation to the rule-based factor or factors relied on in determining the fee award). Consequently, we find no reason to remand the case and no reason to supplement or modify the ALJ's findings on this issue.

Because compensability remained an issue on review, claimant's attorney is entitled to an assessed 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 the compensability issue, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.[2]

ORDER

The ALJ's order dated October 2, 1998 is affirmed. For services on review, claimant's counsel is awarded $1,300, payable by SAIF.

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[1] Specifically, the ALJ noted that he particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved and benefit obtained for claimant and the risk that claimant's attorney's efforts might have gone uncompensated.

[2] Claimant is not entitled to an attorney fee for his counsel's services on review with regard to the attorney fee issue. *See Dotson v. Bohemia,* 80 Or App 233 (1986).

In the Matter of the Compensation of
DON G. MEADOWS, Claimant
WCB Case No. 97-04488
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Biehl, Bock and Moller.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside its partial denial of claimant's current low back condition, diagnosed as spondylosis, stenosis L3-4 and L2-3, a migrating fragment, degenerative disc disease, and claimant's request for surgery. Claimant cross-requests review of that portion of the order that awarded an attorney fee of $4,250, contending that the fee should be increased. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

In 1962, claimant underwent a spinal fusion from L4 through S1. In January 1995, claimant injured his low back while lifting a box of meat while working for the employer. He experienced pain in his low back that radiated into his left hip and down his left leg. Dr. Greenleaf stated that claimant's symptoms were "consistent with L5-S1 radiculopathy due to work injury." (Exs. 3, 4). An MRI of claimant's low back revealed lumbar spondylosis, spinal stenosis at L3-4, multilevel disc herniations, and degenerative changes. The insurer accepted nondisabling "low back with radiculopathy." Claimant was declared medically stationary as of July 25, 1995. (Exs. 13, 16, 18).

In August 1996, claimant sought evaluation for back pain and radiating left buttock, thigh and calf pain with left foot numbness that had recurred over the prior two months. Claimant was diagnosed with lumbar strain, radiculopathy and spinal stenosis at L2-3 and L3-4, and a migrating disc fragment at L3-4, for which surgery was recommended. (Exs. 18B, 28, 29). On April 4, 1997, the insurer denied claimant's current low back conditions on the basis that the January 1995 injury had combined with his preexisting lumbar spondylosis, and that the preexisting condition, not his injury, was the major contributing cause of his current condition and need for treatment. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Under *Georgia Pacific v. Piwowar*, 305 Or 494, 501-02 (1988), a carrier is prohibited from denying the compensability of conditions it has previously accepted. If it has accepted symptoms rather than conditions, it is prohibited from denying the underlying conditions that are responsible for those symptoms.

The ALJ concluded that, under *Piwowar*, the insurer's acceptance of "low back with radiculopathy" encompassed all of claimant's denied low back conditions and set aside the insurer's current condition denial. On review, the insurer first contends that *Piwowar* does not apply, because the insurer's acceptance of "low back with radiculopathy" was an acceptance of a condition, namely "radiculopathy," and not a symptom. Second, the insurer contends that the January 1995 injury is not the major contributing cause of any of the denied conditions. We affirm the ALJ's opinion, with the following supplementation regarding the insurer's argument on review.

Claimant underwent an L5-S1 fusion in 1962. On January 31, 1995, claimant injured his low back when he lifted a heavy load of meat at the employer. Dr. Greenleaf diagnosed mild L5 radiculopathy secondary to the work injury. An MRI showed "moderately severe lumbar spondylosis with evidence of marked spinal stenosis at L3-4 and multilevel disc herniations." The insurer accepted a nondisabling "low back with radiculopathy." On July 25, 1995, claimant was declared medically stationary. On August 9, 1996, claimant sought treatment from Dr. Miller for recurring low back pain with radiation into his left buttock, thigh and calf and numbness in the left foot. On August 23, 1996, claimant sought evaluation from Dr. McWeeney, who diagnosed lumbar strain radiculopathy. After reviewing the MRI, he diagnosed spinal stenosis, which he treated with epidural steroid injections.

Because these injections failed to give complete relief, McWeeney obtained a CT myelogram, which revealed severe spinal stenosis at L3-4, L2-3 and a disk fragment behind the L4 vertebral body for which he recommended surgery. He referred claimant to Dr. Calhoun for surgery and claimant sought to reopen his claim. The insurer denied the current low back condition (including lumbar spondylosis; stenosis at L3-4, L2-3; migrating fragment; surgical request for bilateral L3-4 hemilaminotomy and microdiscectomy; and degenerative disc disease) on the basis that his preexisting underlying degenerative condition, including lumbar spondylosis and stenosis, and not his injury, was the major contributing cause of his current condition. Claimant then requested a hearing.

In *Piwowar*, the carrier accepted a claim for a "sore back." Later, it was determined that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of the preexisting disease. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." 305 Or at 501. In other words, the cause of the original injury does not determine the scope of the employer's acceptance. Instead, "the scope of acceptance corresponds to the condition specified in the acceptance notice[.]" *Id.* The Court then concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, it was precluded from denying the underlying condition. *Id.*

Here, the first question to be answered is whether the insurer's acceptance of claimant's "low back with radiculopathy" was an acceptance of a symptom of his degenerative condition(s) or an acceptance of a separate condition.

In his chart notes, Dr. Greenleaf referred to claimant's low back with radiculopathy both as a condition and as a symptom.[1] In a letter responding to a question from the insurer, he stated: "It is my opinion that Mr. Meadows' injury of January 31, 1995 is the main contributing cause for his current low back and radicular *symptoms* * * * ." (Ex. 10). Dr. Greenleaf also stated that claimant's preexisting fusion was not contributing to the injury incident. (*Id.*) Dr. Greenleaf did not state that claimant's preexisting condition was the sole cause of the accepted "low back with radiculopathy;" instead, he opined that it was the major cause.

Dr. Rosenbaum diagnosed claimant with spinal stenosis with minimal residual left radicular *symptoms*. (Ex. 13-3). Rosenbaum explained: "[Claimant] has pre-existing lumbar spondylosis. This caused spinal stenosis. It was *asymptomatic* until his incident of 1/31/95. It became *symptomatic* with irritation of the nerve root but now appears to be receding. I expect that his *symptoms* will completely resolve although it is conceivable he will have a recurrence of his *symptoms* on a continuous basis. * * * ." (*Id.*). Rosenbaum, in a supplementary report, stated: "[Claimant] had pre-existing lumbar spondylosis which was *asymptomatic*. The incident of 1/31/95 combined with this preexisting condition to produce disability and the need for treatment. The incident was therefore the major contributing cause of the treatment as it produced a radiculopathy. It remains the major contributing cause * * * * *. He still has minor residual *radicular pain* as a result of that incident * * * * *. (Ex. 15-2). Dr. Greenleaf concurred. (Ex. 16). On February 27, 1996, Dr. Greenleaf opined that claimant was medically stationary "with respect to his L5-S1 spondylosis with L5 nerve root impingement." (Ex. 18).

Both Dr. Greenleaf and Dr. Rosenbaum referred to claimant's radiculopathy as a *symptom*. Moreover, although Dr. Zivin's reference to a "left L5 nerve root contusion" is a reference to a condition, the insurer did not accept that condition, but instead accepted symptoms of the underlying low back stenosis and spondylosis, *i.e.*, low back with radiculopathy.[2]

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[1] "[Claimant] felt the acute onset of pain that radiated down into his left hip and down the outside border of his left leg. * * * [H]e does have problems with the radiating *symptoms*." (Ex. 3-1). "Impression: [Claimant] with question of very mild L5 radiculopathy secondary to work injury." *Id.* "Claimant is still experiencing some numbness and tingling in his left leg, down its lateral aspect. This is consistent with an L5-S1 radiculopathy." *Id.* "Mild L5 radiculopathy secondary to work injury." (Ex. 4).

[2] The insurer relies on *Stedman's Medical Dictionary* (24th ed. at 1186) and *Dorland's Medical Dictionary* (27th ed. at 1405) as well as our recognition of "radiculopathy" as a condition in *Mitchell J. Thompson*, 50 Van Natta 289 (1998). The insurer's contentions are not well-taken. First, as noted above, whether an acceptance refers to a condition or a symptom is a factual determination in each case. Second, such a determination was not before us in *Thompson*. Rather, the question raised in that case was whether the acceptance of "radiculopathy" encompassed a combined condition.

Based on this medical evidence, we conclude that claimant's "radiculopathy" was a symptom of claimant's accepted condition and not a separate condition. Therefore, the ALJ correctly applied *Piwowar*, and concluded that the insurer was precluded from denying claimant's current low back condition.[3]

Attorney Fees at Hearing

Claimant contends that the attorney fee awarded by the ALJ for services at hearing should be increased from $4,250 to $7,500, as was requested in his counsel's statement of services. The insurer does not object to the requested amount on review.

Claimant argues that approximately 43 hours of attorney time were invested through the hearing level and relies on the factors set out in OAR 438-015-0010(4). In particular, claimant relies on the following factors: the time devoted to the case (43 hours); the complexity of the issue involved; the value of the interest and the benefit secured for claimant (compensability of spondylosis, stenosis, a migrating disc fragment, degenerative disc disease, and low back surgery); the skill of the attorney (over 15 years in workers' compensation representation); and the risk that counsel's efforts might go uncompensated. Claimant also relies on *Schoch v. Leopold & Stevens*, 144 Or App 261 (1996) to argue that we should consider a multiplier to reflect the contingency nature of Oregon workers' compensation litigation.

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.

Here, claimant's counsel spent approximately 43 hours on the case at the hearing level. Sixty-two exhibits were received into evidence, eight of which were generated or submitted by claimant's counsel. In addition, there was one deposition of a physician. Moreover, prior to hearing, claimant's attorney expended additional time and effort seeking medical evidence to support claimant's claim. The hearing lasted forty-five minutes and the hearing transcript was 24 pages long. Claimant testified on his own behalf. No other witnesses testified. Written closing arguments were submitted.

The issue in dispute was the compensability of claimant's current low back conditions, namely spondylosis, stenosis, a migrating disc fragment, degenerative disc disease, and low back surgery. Considering claimant's prior medical history, the compensability issue was at a level of complexity beyond those compensability/medical disputes that are typically tried before the Hearings Division. The value of the interest involved and the benefits secured for claimant were significant in that the low back and disc condition required surgery and claimant will now receive medical and other benefits for that condition. Both attorneys were skilled and experienced in the area of workers' compensation law and presented their arguments in a thorough and well-reasoned manner. In addition, the value of the claim may potentially include permanent disability benefits. No frivolous issues or defenses were asserted. Because there was divided medical evidence and a vigorous defense, we find that there was a significant risk that claimant's counsel's efforts might have gone uncompensated.

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[3] Like the dissent, we recognize that ORS 656.262(6)(c), which was promulgated subsequent to the Court's decision in *Piwowar*, permits a carrier to subsequently deny an accepted "combined or consequential" condition if the otherwise compensable injury ceases to be the major contributing cause of that condition. Unlike the dissent, we do not find that provision applicable in this case.

For the reasons expressed above, we have found that the insurer's acceptance encompassed claimant's degenerative conditions. As such, those conditions do not constitute "preexisting conditions" for purposes of ORS 656.005(7)(a)(B). *See Raymond J. Suek, Sr.*, 49 Van Natta 706, 707 (1997). Because there is no evidence that the compensable degenerative low back condition combined with any preexisting condition, the insurer did not accept a "combined condition." In this respect, we distinguish *Thompson*, where the medical evidence established that the claimant's radiculopathy had been accepted as a "combined condition."

After considering this matter in light of claimant's contention and the lack of objection by the insurer, we find, after applying the factors discussed above, that the attorney fee award should be increased to $5,500 as a reasonable attorney fee for claimant's counsel's services at hearing. In awarding this fee, we have particularly relied on the medical complexity of the compensability issue, the time devoted to the compensability issue (as represented by the record), the value of the interest involved, the benefits secured, and the risk that counsel might go uncompensated.[4]

Attorney Fee on Board Review

Claimant's attorney is also entitled to an assessed fee for services rendered in defending against the insurer's request for review regarding the compensability issue. *See* ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an assessed fee for services provided regarding claimant's cross-appeal on the attorney fee issue.

ORDER

The ALJ's order dated April 30, 1998 is affirmed in part and modified in part. In lieu of the ALJ's award of a $4,250 assessed attorney fee for services at hearing, claimant's attorney is awarded an assessed fee of $5,500 for services at hearing, to be paid by the insurer. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $1,500, to be paid by the insurer.

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[4] In reaching this conclusion, we reiterate that we do not use a contingency factor in a strict mathematical sense. *See Lois J. Schoch*, 49 Van Natta 170, 173 n.1 (1997). Instead, in conjunction with the other relevant factors discussed above, the risk that claimant's counsel might go uncompensated for services rendered in this proceeding has been considered in our ultimate determination of a reasonable attorney fee.

Board Member Moller dissenting.

I disagree with the majority's conclusion that the insurer was precluded by application of *Georgia-Pacific v. Piwowar*, 305 Or 494 (1988), from denying claimant's current low back condition. Because the insurer initially accepted a combined condition, its subsequent denial was permissible pursuant to ORS 656.262(6)(c). Further, based on the most persuasive medical evidence, claimant has failed to establish compensability of his current condition. Accordingly, I must respectfully dissent.

The insurer in this case voluntarily accepted as compensable nondisabling "low back with radiculopathy." Prior to 1995, the Supreme Court's decision in *Piwowar* would have operated to preclude the carrier from subsequently denying the previously accepted condition.[1] However, in 1995, the legislature partially overturned the Supreme Court's *Piwowar* holding. As enacted in 1995, ORS 656.262(6)(c) expressly allows a carrier to subsequently deny a previously accepted "combined or consequential" condition if the "otherwise compensable injury ceases to be the major contributing cause" of that condition. *See Drews v. EBI Companies*, 310 Or 134, 141 (1990) (preclusion rules subject to exception where, by provision of statute, determination does not bar another action or proceeding on same claim).

The majority determines that the insurer's acceptance of "radiculopathy" was an acceptance of a symptom of claimant's underlying condition(s) so that, under *Piwowar*, the insurer was precluded from denying the underlying condition(s). The majority's analysis is incomplete. A complete analysis requires a determination whether the accepted underlying condition was a combined condition, thereby invoking the provisions of ORS 656.262(6)(c) and allowing a denial of the previously accepted condition.

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[1] As further discussed herein, whether the insurer accepted a condition or a symptom of the underlying condition(s) is not determinative in light of the provisions of ORS 656.262(6)(c).

We applied such an analysis in *Mitchell J. Thompson*, 50 Van Natta 289 (1998), a case which is both legally and factually quite similar to the matter now before us. In that case, as here, the claimant experienced a lifting injury at work. As is also true here, the claimant's physicians in *Thompson* diagnosed multiple elements of preexisting degenerative disc disease, with the onset of radiculopathy following the injury. The carrier accepted disabling "cervical radiculopathy." Subsequently, based on medical opinions, the carrier denied the claimant's current cervical radiculopathy condition on the basis that his 1995 injury was no longer the major cause of his current condition and related disability. We concluded that the carrier's pre-closure denial was valid under ORS 656.262(6)(c).

We began our analysis by applying *SAIF v. Tull*, 113 Or App 449, 454 (1992), in which the court held that whether an acceptance occurs is an issue of fact. The notice of acceptance in *Thompson* did not state that the claimant's "radiculopathy" was accepted as a combined condition. Therefore, we concluded that the acceptance was ambiguous as to whether the carrier voluntarily accepted the claimant's radiculopathy as a combined condition. We next examined the record and found that the claimant suffered from preexisting degenerative disc conditions, which had combined with his lifting injury at work to result in radiculopathy. Based on these circumstances, we concluded that the carrier had voluntarily accepted the claimant's cervical radiculopathy condition as a combined condition under ORS 656.005(7)(a)(B). Finally, relying on the most persuasive medical opinion, we found that the claimant's injury had ceased to be the major contributing cause of his current condition and need for treatment. Consequently, we upheld the carrier's denial pursuant to ORS 656.262(6)(c).

My analysis in this case would be similar to that applied in *Thompson*. Here, as in *Thompson*, the insurer's acceptance of "low back with radiculopathy" is ambiguous, as the acceptance did not state that claimant's "low back with radiculopathy" was accepted as a combined condition. The medical evidence, however, indicates that claimant's lumbar spondylosis, stenosis and degenerative disc disease at L4-5 and L5-S1 preexisted and combined with his January 1995 lifting injury and resulted in L5 radiculopathy. (Exs. 3, 9,10, 13-4, 15-2). Therefore, I would conclude that the insurer voluntarily accepted claimant's low back radiculopathy condition as a combined condition under ORS 656.005(7)(a)(B).

Claimant had no treatment for his low back from April 27, 1995 until August 9, 1996, when he sought medical attention for low back pain radiating into the left leg, which he had experienced for about two months. Dr. McWeeney and Dr. Zivin each diagnosed degenerative disease of the low back (spondylosis, stenosis), which they opined was the major contributing cause of claimant's current need for treatment. (Exs. 18C, 19, 23, 30). Dr. Calhoun, in contrast, thought claimant's primary problem was central stenosis and a migrating disc fragment at L3-4 and recommended surgery at that level. However, there is no medical evidence contemporaneous with the January 1995 injury that the source of claimant's symptoms from the combined condition resulted from the L3-4 level. Therefore, I would find persuasive Dr. McWeeney's and Dr. Zivin's opinion that the major contributing cause of claimant's current condition is his preexisting degenerative conditions (including lumbar spondylosis and L3-4 and L2-3 stenosis).

In sum, because the insurer accepted a combined condition, its denial of claimant's current conditions is valid. Therefore, addressing the merits of the compensability issue, I would find that claimant has failed to prove that his current low back condition is compensable. Because the majority comes to the contrary conclusion, I dissent.

In the Matter of the Compensation of
KAREN S. MOORE, Claimant
WCB Case No. C9-00390
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

On March 5, 1999, 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 her rights to future workers' compensation benefits, except medical services, for the compensable injury.

On February 23, 1999, we wrote the parties requesting clarification of the date of injury. The date of injury provided in the CDA (July 29, 1997) conflicted with the date provided in the Board's records (March 8, 1998). On March 3, 1999, we received a response from claimant's counsel stating that claimant's original injury date was July 29, 1997, but that claimant sustained another injury to the same body part and that both injuries were included as part of the same claim. We approved the CDA on March 5, 1999.

Also on March 5, 1999, we received a letter from the carrier's attorney stating that the CDA should be amended to reflect that March 8, 1998 was the date of her Oregon injury. The letter explained that claimant originally injured herself on July 29, 1997, while working for the employer in Washington State. We treat the carrier's attorney's letter as a motion for reconsideration of the approved CDA.

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 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.

Based on the letters from claimant's counsel and the carrier's counsel clarifying the date of injury, we interpret the CDA as follows. Claimant was injured on January 29, 1997, while working for the employer in another state. As a practical matter, the carrier has treated claimant's second injury, which occurred on March 8, 1998 in Oregon, as part of the January 29, 1997 claim. However, the CDA can only pertain to an accepted claim under Oregon law; *i.e.*, to the Oregon injury which occurred on March 8, 1998. Thus, we find that the correct date of injury is March 8, 1998.

On reconsideration, we find that the amended agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). Accordingly, the CDA , as amended by the parties' counsel's letters and this order, 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. MYERS, Claimant
WCB Case No. 98-05769
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Moller and Biehl.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order that awarded an assessed fee of $4,250 pursuant to ORS 656.386(1). SAIF also moves to remand regarding the attorney fee issue. On review, the issues are attorney fees and remand.

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

The ALJ awarded claimant's attorney an assessed fee of $4,250. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in determining the amount of the attorney fee. SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award.

We considered similar arguments in *Daryl L. Underwood*, 50 Van Natta 2330 (1998); *see also Garry L. Mercer*, 51 Van Natta 322 (1999). In *Underwood*, 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 Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

Here, however, the ALJ simply stated: "For prevailing against the denial claimant's attorney is awarded an assessed fee in the sum of $4,250." Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), we agree with SAIF that the ALJ did not provide reasoning sufficient for review. *See John P. O'Connor*, 51 Van Natta 312 (1999); *Carol E. Brown*, 51 Van Natta 58 (1999). Nevertheless, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation 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 2330.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The record contains no statement of services documenting the time claimant's attorney spent on the case. The issue was compensability of claimant's low back condition. The hearing lasted 1 hour and generated 11 pages of transcript. Claimant was the only witness. The record contains approximately 35 exhibits, one of which was submitted by claimant's attorney. There were two depositions, lasting a total of approximately 35 minutes and generating 32 pages of transcript.

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. Because claimant's low back 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $4,250, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the nature of the proceedings (including the depositions), the value of the interest involved, and the risk that counsel may go uncompensated.[1]

ORDER

The ALJ's order dated December 23, 1998 is affirmed.

[1] 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, *rev den* 302 Or 35 (1986).

March 18, 1999 Cite as 51 Van Natta 452 (1999)

In the Matter of the Compensation of
PATRICIA PARKER, Claimant
WCB Case No. 97-09279
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's denial of her occupational disease claim for a left 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 the insurer's denial of claimant's left CTS, finding that claimant's treating physician, Dr. Sandefur, did not have a complete understanding of her activities on and off the job when he opined that claimant's left carpal tunnel condition was caused in major part by her work activities at the employer. On review, claimant asserts that Dr. Sandefur's opinion is sufficient to establish compensability. 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. Sandefur acknowledged that claimant had experienced symptoms of carpal tunnel syndrome on the left that preexisted her employment. (Exs. 1, 22-27). Dr. Sandefur also conceded that claimant's off-work activities, including quilting, knitting and gardening, contributed to her disease. (Exs. 22-19, -39). Therefore, to establish a compensable occupational disease, claimant must prove both that her work is the major contributing cause of her combined condition and that her left carpal tunnel syndrome has pathologically worsened. ORS 656.802(2)(b); *see Dan D. Cone*, 47 Van Natta 1097, *on recon* 47 Van Natta 2220, *on recon* 47 Van Natta 2343 (1995).

Dr. Sandefur stated that claimant's repetitive work combined with and was the major contributing cause of her disability and need for treatment of the combined left wrist condition. (Ex. 22-27, -33, -35, 36). He also stated twice during deposition that her work activities "aggravated the symptoms to the point where she couldn't be treated conservatively" and required surgery. (Ex. 22-33, -35). Dr. Sandefur's statements, however, do not confirm that claimant's work activities pathologically worsened claimant's CTS.

Therefore, based on our *de novo* review, even if Dr. Sandefur's opinion was based on a complete understanding of claimant's concurrent activities, it is not sufficient to establish a compensable occupational disease claim.

ORDER

The ALJ's November 27, 1998 order is affirmed.

In the Matter of the Compensation of
RICK J. PICKRELL, Claimant
WCB Case Nos. 98-05334 & 98-03013
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Steven T. Maher, Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Bock.

Business Insurance Company, on behalf of Oregon Staffing, requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) set aside its compensability and responsibility denials of claimant's left inguinal hernia condition; and (2) upheld Employers Overload's responsibility denial of the same condition. On review, the issues are compensability and responsibility.

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

Responsibility

Business Insurance Company, on behalf of Oregon Staffing (OS), argues that the ALJ erred by applying the last injurious exposure. OS contends that the last injurious exposure rule only applies after a worker has invoked the rule to prove compensability. We disagree.

Even if a claimant has chosen to prove actual causation, a carrier may rely on the last injurious exposure rule of responsibility as a defense. *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 81 (1997). In *Safeco Ins. Co. v. Victoria*, 154 Or App 574 (1998), the Board agreed with the ALJ's conclusion that the last injurious exposure rule did not apply because the claimant had established that her prior employment was the "actual cause" of her condition. The court reversed, holding that the last injurious exposure rule of responsibility applies to assign responsibility because the record showed that the claimant's work at both employments contributed to her condition. *Id.* at 577-78.

Here, we agree with the ALJ's reasoning and conclusion that claimant's left inguinal hernia initially developed while working for Employers Overload (EO) and worsened while working for OS. Claimant first sought treatment for his hernia condition while working for the later employer (OS) and, therefore, OS is initially (or presumptively) responsible. *Reynolds Metals v. Rogers*, 157 Or App 147,153 (1998); *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994) (if a claimant received medical treatment before experiencing time loss, the date the claimant first received treatment is the triggering date for the initial assignment of responsibility). An employer that otherwise would be responsible under the last injurious exposure rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease in this particular case; or (2) that the disease was caused solely by conditions at one or more previous employments. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). We find no such evidence in this case. We agree with the ALJ that the persuasive medical opinions from Drs. Ragsdale and Cowell establish that claimant's employment at EO and OS both contributed to his hernia condition. We conclude that responsibility for claimant's left inguinal hernia condition rests with OS.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by Business Insurance Company, on behalf of Oregon Staffing. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's affidavit in support of an attorney fee), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 30, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by Business Insurance Company, on behalf of Oregon Staffing.

In the Matter of the Compensation of
TIMOTHY M. STRATEGOS, Claimant
WCB Case No. 98-03677
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its partial denial of claimant's low back condition; and (2) awarded a penalty for untimely claims processing. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right thigh on May 24, 1997, when he was pinned between a pallet jack and a trailer. (Ex. 4). Claimant was treated the next day by Drs. Maskell and Podett, who diagnosed a minor right thigh contusion, prescribed pain medication, and released him to modified work for three days. Maskell noted that claimant's gait was normal and that claimant's pain was out of proportion to his physical examination. (Ex. 6-1). On June 18, 1997, Dr. Podett released claimant to regular work, and, on June 25, 1997, reported that claimant's right thigh condition had resolved. (Exs. 12, 15).

On August 22, 1997, the insurer accepted a disabling right thigh contusion and issued a Notice of Closure that awarded no permanent disability. (Ex. 21, 22).

On September 11, 1997, claimant sought treatment from Dr. Saks for pain in his right thigh, which he attributed to the May 1997 injury. Claimant also reported that his back hurt originally, but had resolved. Saks diagnosed claimant with a right thigh strain and a chronic lumbar strain secondary to overcompensation, for which he prescribed chiropractic treatment. (Ex. 26-1, 28).

On November 19, 1997, Drs. Wilson, Strum and Davies began an evaluation for the insurer that was terminated after 30 minutes because of claimant's disruptive behavior. After reviewing the records and treatment notes, Dr. Davies concluded that they were consistent with, *inter alia,* symptom migration and a personality disorder. Davies opined that claimant's emotional problems were significantly contributing to his disability behaviors. (Ex. 33).

On December 11, 1997, Dr. Gritzka, medical arbiter, examined claimant. (Ex. 34).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, although claimant's testimony was difficult to track and that he was not a good historian, the history as a whole he presented at hearing was consistent with the medical record. Based upon that history, the ALJ concluded that, because Dr. Saks' and Dr. Clunes' opinions related claimant's low back complaints to the right thigh injury, claimant met his burden of proof. We disagree for the following reasons.

The parties agree that claimant's low back condition should be analyzed as a consequential condition. After reviewing the record, we conclude that claimant has failed to meet his burden of proof. See ORS 656.005(7)(a)(A); *Albany General Hospital v. Gasperino,* 113 Or App 411 (1992). The causation of claimant's low back condition presents a complex medical question, the resolution of which largely turns on an analysis of the medical evidence. *See Uris v. Compensation Department,* 247Or 420, 426 (1967); *Kassahn v. Publishers Paper Co.,* 76 Or App 105, 109 (1985), *rev den* 300 Or 546 (1986).

Dr. Saks and Dr. Clunes each attributed claimant's low back strain to overcompensation in the low back as a result of claimant's altered gait in the right leg. (Exs. 39, 40). The record, however, does not support their opinions.

Claimant testified that he started limping when he got pinned by the jack and limped for the next three months. (Tr. 27). Although claimant testified that he "hurt all over" after the injury, he reported his right thigh injury immediately after the May 1997 injury, but no limping or low back complaints were documented until September 1997, four months later, when he started waking up with back pain and stiffness. (Ex. 8). In addition, claimant had been treated for back complaints on several occasions prior to the May 1997 injury, most recently in September 1996. (Tr. 12, 13, 21, 22; Ex. 2-1). Moreover, claimant testified that he went to work at a different employer doing distribution on or about August 24, 1997, and that he quit working when his back started bothering him and sought treatment from Dr. Saks. (Tr. 18, 19). Finally, Dr. Maskell, Dr. Saks and Dr. Davies noted that claimant's symptoms were out of proportion to the injury and that there was a psychological component to his complaints. (Exs. 6, 26, 33-4).

Because of the discrepancies between the medical record and claimant's history, on which Dr. Saks and Dr. Clunes relied, and their failure to discuss the possible contribution of the identified off-the-job factors to his low back condition, we find their opinions unpersuasive and decline to rely on them. *See 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); *Somers v. SAIF*, 77 Or App 259 (1986). Therefore, we conclude that the medical opinions are insufficient to establish that claimant's compensable right thigh injury was the major contributing cause of his low back condition.

Finally, although the insurer conceded that its denial was untimely, because there is no compensation due, no penalty is payable.

ORDER

The ALJ's order dated November 5, 1998 is reversed. The insurer's denial is reinstated and upheld. The ALJ's penalty and attorney fee awards are reversed.

March 18, 1999 Cite as 51 Van Natta 455 (1999)

In the Matter of the Compensation of
CATHERINE G. RENFRO, Claimant
WCB Case Nos. 96-02773 & 95-11919
ORDER ON REMAND
Dobbins, McCurdy & Yu, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Intel Corporation v. Renfro*, 155 Or App 447 (1998). The court has reversed our prior order, *Catherine G. Renfro*, 49 Van Natta 1165 (1997), that had affirmed the Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's aggravation claim for a fistula condition. Before proceeding with our reconsideration in accordance with the court's decision, we received notice that the parties had resolved this matter pursuant to a Claim Disposition Agreement (CDA).

On March 16, 1999, we approved the parties' CDA, in which claimant released all of her "non-medical services" rights to workers' compensation benefits (including temporary disability, permanent disability, temporary disability relating to aggravation and Own Motion claims, and penalties and attorney fees for "pre-CDA approval" disputes) related to her July 1982 claim.

In light of our approval of the parties' CDA (which contains the aforementioned provisions), we conclude that the aggravation issue raised on remand has been rendered moot. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRI A. BRIGGS-TRIPP, Claimant
Own Motion No. 94-0730M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Foster A. Glass, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our January 12, 1999 Own Motion Order Reviewing Carrier Closure, which set aside the employer's September 15, 1998 Notice of Closure as premature. On February 10, 1999, we abated our prior order to allow claimant sufficient time to respond to the employer's motion. On reconsideration, after considering the employer's submission and claimant's response, we adhere to the conclusion reached in our January 12, 1999 order. We base this decision on the following reasoning.

In our January 12, 1999 order, we relied on Dr. Higdon's October 2, 1998 medical report in finding that claimant was not medically stationary on September 15, 1998, when the employer closed the claim. *See Christi McCorkle*, 48 Van Natta 840 (1996). In April 1998, after completing treatment of a pain center, the pain center physicians declared claimant medically stationary and returned her to full work. They also scheduled several follow-up appointments to monitor claimant's nicotine and narcotic use, recommending that she follow-up with Dr. Higdon on a monthly basis for at least six months. Dr. Higdon concurred with the pain center's discharge report.

Dr. Higdon's October 2, 1998 report offered a different opinion regarding claimant's medically stationary status at the time of claim closure. Dr. Higdon explained that he had recognized the need for implant surgery prior to her entering the pain center. However, he agreed that she was medically stationary in April of 1998, because surgery at that time would not be considered until sufficient time had elapsed to allow claimant to get her chronic pain under control.

The employer argues that Dr. Higdon's October 2, 1998 report does not address claimant's medically stationary status at the time of closure because the pain center and Dr. Higdon both agreed that claimant would not be considered for implant surgery for at least six months and that time period had not yet lapsed when the employer closed the claim. Therefore, the employer argues that claimant's medical condition changed from the September 15, 1998 closure and Dr. Higdon's October 1998 report. As a result, the employer reasons that Dr. Higdon's October 1998 report does not address claimant's medically stationary status at closure.

In response to the employer's motion for reconsideration, claimant submitted an February 16, 1999 report from Dr. Higdon, several chart notes dating from February 1998 through December 1998, and correspondence between Dr. Higdon and Dr. Judy. The chart notes demonstrate that, not only did claimant seek treatment from Dr. Higdon on an almost weekly basis since her discharge from the pain center, but she had also undergone two surgical procedures (*i.e.* tissue grafts) in May and July 1998. These procedures were designed to materially improve claimant's compensable condition and prepare her for the recommended implant surgery.

As early as July 1998, Dr. Higdon's change of opinion regarding claimant's need for surgery became apparent in his correspondence with Dr. Judy. He stated that "I am convinced now, in spite of any other considerations, such as her tendency to become dependent on pain meds, that until she had some kind of dependable posterior support, there will be no-long term answers for her. I want you to look seriously at placement of some implants." These comments are persuasive evidence that Dr. Higdon did not want to wait the proposed six month period before claimant could undergo her implant surgery. Because this change of opinion was rendered prior to the employer's September 1998 closure, it supports a conclusion that claimant's condition was not medically stationary when the claim was closed.

Although we partially relied on Dr. Higdon's October 1998 report to conclude that claimant was not medically stationary at the time of closure, we also reviewed the record as a whole to support that conclusion. In our January 12, 1999 order, we also found that claimant had continually sought medical treatment with Dr. Higdon since her discharge from the pain center and as a result, Dr. Higdon recanted his original opinion to wait six months before scheduling the implant surgery. Additionally, we found that the surgery was designed to materially improve claimant's compensable injury.

Our conclusion is supported by Dr. Higdon's February 16, 1999 report, which further explained his change of opinion regarding claimant's medically stationary status. He stated that when he made the referral to the pain center, he did not anticipate that the center would propose as a condition of her entering the program, a prolonged delay before undergoing surgery. However, Dr. Higdon reluctantly concurred with the center because he was "between a rock and a hard place." Acknowledging that claimant did benefit from the pain program, Dr. Higdon decided to "push ahead" with the implants, contrary to his prior agreement with the pain center. The basis for Dr. Higdon's decision was that claimant remained in constant pain and would gain some dental stability and reach a point of maximum improvement.

Based on the record (particularly Dr. Higdon's persuasive explanation for the evolution and change in his opinion), we are persuaded that further material improvement in claimant's compensable condition was reasonably expected at the time of the September 1998 claimant closure; *i.e.* claimant's attending physician supported the need for dental implant surgery. Under such circumstances, we continue to find that claimant was not medically stationary at the time the employer closed her claim. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our January 12, 1999 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 19, 1999 Cite as 51 Van Natta 457 (1999)

In the Matter of the Compensation of
LINDA A. JONES, Claimant
WCB Case No. 98-01961
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

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

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

In arguing that the ALJ incorrectly upheld the insurer's denial, claimant contends that the opinion of Dr. Nathan, an examining physician, supports the compensability of her claim. She cites a portion of Dr. Nathan's deposition in which he apparently agrees that claimant's employment caused progression of her preexisting left thumb arthritis. (Ex. 39-14).

Dr. Nathan, however, corrected that portion of the deposition transcript to indicate that he did *not* agree that claimant's employment caused whatever progression of claimant's thumb arthritis may be present. (Ex. 39-16). Accordingly, we do not find that Dr. Nathan's opinion supports a finding of compensability. Moreover, we agree with the ALJ's reasons for concluding that claimant failed to prove a compensable occupational disease.

ORDER

The ALJ's order dated November 27, 1998 is affirmed.

In the Matter of the Compensation of
CLARENCE W. THOMAS, Deceased, Claimant
WCB Case No. 97-06384
ORDER ON REVIEW
Sather, Byerly, et al, Attorneys
Meyer & Wyse, Attorneys

Reviewed by Board Members Moller and Biehl.

The alleged employer, Fleet Delivery Service (Fleet), requests review of Administrative Law Judge (ALJ) Mills' order that dismissed its request for hearing from the SAIF Corporation's denial of a claim based on the decedent's alleged injury.[1] On review, the issue is the propriety of the ALJ's dismissal order.

We adopt and affirm the ALJ's order with the following supplementation.[2]

The deceased was involved in a motor vehicle accident (MVA) in California. He later died for reasons unrelated to the MVA. His estate filed civil and workers' compensation claims in California. The deceased did not file a workers' compensation claim in Oregon. On April 1, 1996, the alleged employer filed a claim in Oregon listing the deceased as a claimant. SAIF denied the claim on June 2, 1997 on the ground that the deceased was not a subject worker in Oregon. The employer requested a hearing from the denial.

The ALJ granted SAIF's motion to dismiss the hearing request, finding that the employer lacked standing to pursue its hearing request. Citing *Trice v. Tektronics, Inc.*, 104 Or App 461 (1990), the ALJ reasoned that only those persons entitled to death benefits under ORS 656.204 could pursue a hearing request on behalf of a deceased worker. *See* ORS 656.218(4)&(5).[3] Because claimant left no individuals eligible for death benefits under ORS 656.204, and because the employer could not be a beneficiary under the statute, the ALJ determined that the employer could not pursue its hearing request.

On review, the employer contends that it has an independent statutory right under ORS 656.283(1)[4] to establish the compensability of a claim and the fact that the worker is deceased does not deprive it of standing or the Board of jurisdiction. We disagree.

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[1] SAIF requests that we ask the employer's counsel to confirm that she represents only the employer or, alternatively, to disclose all parties she does represent. For purposes of our review, we are only concerned about whether the employer's counsel represents Fleet, the alleged employer. Her representation, insofar as it pertains to Fleet, is not disputed. Whether the employer's counsel represents other parties is not important to the determination of the issues presented in this case. Therefore, while SAIF may wish to submit its inquiry directly to Fleet's counsel, we decline SAIF's request.

[2] The employer requests that the case be set for oral argument. We will not ordinarily entertain oral argument. OAR 438-011-0015(2). We may allow oral argument, however, where the case presents an issue of first impression that could have a substantial impact on the workers' compensation system. *See* OAR 438-011-0031(2); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994). The decision to grant such a request is solely within our discretion. OAR 438-011-0031(3). While this case does present a novel issue, we conclude that the parties have, through legal argument presented in their briefs, adequately addressed the issue before the Board. We are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. *See, e.g. Tim L. Besheone*, 48 Van Natta 2337, n. 2 (1996).

[3] ORS 656.218(4) provides that if the worker dies before filing a request for hearing, "the persons described in subsection (5) of this section shall be entitled to file a request for hearing and to pursue the matter to final determination as to all issues presented by the request for hearing." ORS 656.218(5) provides:

> "The payments provided in this section shall be made to the persons who would have been entitled to receive death benefits if the injury causing the disability had been fatal. In the absence of persons so entitled, a burial allowance may be paid not to exceed the lesser of either the unpaid award or the amount payable by ORS 656.204."

[4] ORS 656.283(1) provides:

> "Subject to ORS 656.319, any party or the Director of the Department of Consumer and Business Services may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, including ORS 656.245, 656.248, 656.260, 656.327 and subsection (2) of this section."

In *Timothy W. Stone*, 50 Van Natta 2421 (1998), a case decided after the ALJ's order, we dismissed a claimant's request for review of an ALJ's compensability decision because the claimant died pending review and was not survived by a "death beneficiary" under ORS 656.218(3) and ORS 656.204. In *Stone*, following an initial Board order finding a claim compensable, a carrier moved for reconsideration and dismissal of the appeal, contending that the claimant had died prior to the Board's decision without leaving a death beneficiary. In response, the personal representative for the claimant's estate (the decedent's 20-year old daughter, who was a high school graduate and not pursuing further formal education) did not challenge the carrier's assertion regarding the lack of a death beneficiary. Instead, the personal representative argued that the estate was entitled to pursue the claim in order to obtain reimbursement for unpaid medical bills.

We acknowledged the public policy issue presented by the personal representative's argument. Nonetheless, relying on *Edwards v. Cherry City Electric, Inc.*, 141 Or App 578(1995), and *Trice v. Tektronix, Inc.*, we determined that we were not authorized to recognize a so-called "medical bill" exception to ORS 656.218. In reaching our conclusion, we recognized that the claimants' estates in *Edwards* and *Trice* were pursuing disability benefits, whereas the present claimant's estate was seeking acceptance of a denied condition (and ultimately the payment for medical services). Nevertheless, noting that ORS 656.218(1) used the more inclusive term "compensation," and observing that "medical services" are encompassed within "compensation" under ORS 656.005(8), we concluded that the statutory scheme prescribed in ORS 656.218 for the pursuit of a deceased claimant's appeal was not limited to a claim for disability benefits, but also applied to compensability/medical service claims. Because a personal representative was not one of the persons entitled to pursue the decedent's claim and, because the decedent's daughter did not assert that any "death beneficiaries" under ORS 656.204 existed to continue the appeal, we determined that the request for review must be dismissed.[5]

In accordance with our reasoning in *Stone*, we find that, because the employer is not one of the persons entitled to pursue the decedent's claim under ORS 656.218(4), the ALJ properly dismissed its request for hearing. We recognize that an employer as a "party" may request at any time under ORS 656.283(1) a hearing on a "matter concerning a claim." However, we are not persuaded by the employer's assertion that this statute allows it to pursue an independent claim based on the deceased's alleged injury.

While ORS 656.283(1) allows the employer (as a "party") to file a hearing request regarding a "claim," the employer does not cite any authority for the proposition that this statute also authorizes it to pursue to a final determination an "independent" claim based on the deceased's alleged injury.[6]

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[5] Chair Bock specially concurred. Although conceding that the majority's conclusion was consistent with the statutory scheme as interpreted by *Trice*, Bock submitted that the result created an unjust hardship on the deceased claimant's estate and, potentially, the decedent's medical service providers. Concluding that the lack of "medical service" reimbursement would either result in the depletion of the estate's assets, the failure of the medical service provider to receive full satisfaction for its outstanding bill, or the reimbursement to the provider from another source (public or private), Chair Bock determined that the allegedly responsible entity (i.e., the decedent's employer) would effectively be relieved of its potential liability for medical services due to an apparently work-related injury. Submitting that placing claims for medical services within the same category as indemnity death benefits created an anomalous result and an undue hardship on a deceased worker's "beneficiary-less" estate, Bock suggested that the legislature consider amending the statutory scheme to permit a decedent's estate to seek reimbursement for medical bills.

[6] The employer insists that it is entitled to litigate the deceased's "right" to receive compensation "at the moment of injury" regardless of the worker's life or death. Thus, it asserts that the provisions of ORS 656.218 are not applicable. The employer fails to explain how the objectives of workers' compensation law, one of which is "To provide, regardless of fault, sure, prompt and complete medical treatment for *injured workers* and fair, adequate, and reasonable income benefits to *injured workers* and their *dependents*" (ORS 656.012(2)(a), emphasis supplied), would be furthered by allowing it to litigate the compensability of the deceased's injury. *Cf. Orville L. Carlson*, 37 Van Natta 30 (1985) (since the appellant had prevailed in the order that it was appealing, the Board concluded that the appellant was not an aggrieved party and, therefore, dismissed the appellant's request for review). In other words, because SAIF (the insurer to which the employer has contractually assigned the statutory obligation for processing workers' compensation claims) has denied the claim on the employer's behalf, the employer is not an aggrieved party. Thus, the employer is essentially seeking review of a claim processing action taken by its insurer. We consider this issue to be a contractual dispute between the employer and SAIF and, as such, not a matter concerning a claim subject to review by the Hearings Division and this forum.

Indeed, the only persons authorized to pursue a claim based on a decedent's injury are those beneficiaries provided for in ORS 656.218(5) and ORS 656.204. Inasmuch as there is no dispute that the employer does not qualify for death benefits under those provisions, it is not entitled to pursue a claim based on the deceased's alleged injury. *Trice v. Tektronics, Inc.*, 104 Or App at 465; *Timothy W. Stone*, 50 Van Natta 2421.

ORDER

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

March 22, 1999 Cite as 51 Van Natta 460 (1999)

In the Matter of the Compensation of
LYNN FOSTER, Claimant
WCB Case No. C9-00591
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Swanson, Thomas & Coon, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

On March 8, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 2, number 12, the CDA provides, in part:

> "Pursuant to ORS 656.236, in consideration of the payment of $290,000.00, less: an attorney fee of $20,000.00, and less $26,126.50 advance payments of a permanent disability award (two lump payments totaling $20,500.00, and three monthly payments of $1,875.50 for 12/98, 1/99 and 2/99), for a total remaining consideration of $243,873.50, by the insurer/employer, claimant releases his right to the following workers' compensation benefits * * *. The insurer will continue to pay permanent partial disability until the date the Claim Disposition Agreement is approved by the Board."

Payment of non-medical benefits, including permanent disability benefits, is not stayed until the date the CDA is submitted to the Board. *See* ORS 656.236(1). In addition, temporary and permanent disability benefits legally due and payable prior to submission of the CDA may not be considered an "advancement" of the CDA proceeds. See *Robert Derderian*, 45 Van Natta 1042 (1993). Stated more simply, temporary or permanent disability benefits that are legally due and payable *prior to the submission of the CDA* to the Board cannot be included in the "consideration" for the CDA.

Here, although the parties' CDA mentions the permanent disability benefits and refers to them as an "advance," the benefits are not actually included in the $243,873.50 total consideration for the CDA. Under such circumstances, because the permanent disability benefits are not included within the consideration for the CDA, we conclude that the agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, we approve the CDA.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MARCELLA L. BROOKS, Claimant
WCB Case No. 97-07653
ORDER ON RECONSIDERATION
Mitchell & Associates, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

The insurer requests reconsideration of our February 23, 1999 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that awarded claimant an assessed attorney fee of $750. Contending that there is no "record" or "evidence" to support our decision, the insurer challenges our findings that the insurer raised and rescinded a current condition denial and that $750 is a reasonable assessed attorney fee award. Having received claimant's response and the insurer's reply, we proceed with our reconsideration.

To begin, the record supports a conclusion that the insurer denied claimant's current condition. In our 1997 order, we found that the insurer's initial denial was not a "current condition" denial. Consequently, we recognized the insurer's "precautionary measure to amend the denial to include a current condition denial" (in case we disagreed with its primary allegation that its initial denial encompassed a current condition denial). We vacated the ALJ's denial of the insurer's motion to amend its denial and remanded for consideration of claimant's motion to continue the hearing based on the amended denial. Thus, we allowed the insurer to raise its current condition denial. In light of such circumstances, we reject the insurer's contention on reconsideration that "there is no record to show that [the insurer] *succeeded* in raising a current condition denial."

Turning to the issue of whether the record supports our conclusion that the insurer rescinded its current condition denial, we acknowledge that the record lacks a direct statement from the insurer withdrawing its denial. Nonetheless, neither on Board review nor on reconsideration has the insurer challenged the ALJ's finding that its counsel notified the ALJ and claimant's counsel during a conference call that it "no longer wished to amend the denial." Considering the 1997 Board finding that the insurer had amended its denial to include claimant's current condition and the ALJ's subsequent uncontested finding regarding the insurer's decision to no longer amend its denial, we find that the record establishes that the insurer rescinded its amended denial.[1]

Finally, we reject the insurer's contention that there is no record to support an attorney fee award for claimant's counsel's services in securing the rescission of the insurer's amended "current condition" denial. In reaching this conclusion, we note that, because claimant finally prevailed after remand on the "current condition" denial, his counsel is entitled to an attorney fee for services rendered before every prior forum. *See* ORS 656.388(1). Thus, our review of the record extends to not only the events that transpired subsequent to our 1997 order that remanded this matter to the ALJ, but also includes consideration of claimant's counsel's efforts at the initial hearing and on Board review regarding the amended "current condition" denial issue.

Moreover, claimant's counsel submitted a description of services expended on the "current condition" denial issue and how those services applied to the factors recited in OAR 438-015-0010(4) for the determination of a reasonable insurer-paid attorney fee. Because this submission was filed within the time parameters prescribed in OAR 438-015-0029, it may be considered. *William J. Kephart*, 51 Van Natta 291, n 2 (1999).

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[1] Asserting that in "vocational rehab proceedings" before the Workers' Compensation Division it is contending that claimant's accepted condition has resolved, the insurer challenges our finding that a current condition denial has been withdrawn. Furthermore, noting that vocational rehabilitation issues are outside our jurisdiction, the insurer reasons that any such denial "would have been a nullity, with no fee." Authority to consider vocational assistance issues unquestionably rests with the Director. *See* ORS 656.283(2). Thus, our decision should not be interpreted as addressing any vocational service issues pending between the parties. Nevertheless, as described in our 1997 order, the insurer's "current condition" denial was not confined to merely vocational assistance matters. In light of such circumstances, we disagree with the insurer's argument that consideration of a "current condition" denial was beyond the authority of this forum. Moreover, because such a denial would naturally extend to all rights to benefits under the workers' compensation law, we also reject the insurer's characterization of its "current condition" denial as a nullity.

In conclusion, after consideration of the factors set forth in OAR 438-015-0010(4), we continue to find that an insurer-paid attorney fee of $750 is reasonable for claimant's counsel's services regarding the insurer's rescinded "current condition" denial. In addition to the factors that we have particularly noted in our prior order, we have also taken into consideration the extended nature of the proceedings; *i.e.* claimant's counsel's services (as represented by the record and claimant's initial respondent's brief in the 1997 review proceeding) at the initial hearing, on Board review, and before the ALJ on remand in finally prevailing over the insurer's amended "current condition" denial.

Accordingly, we withdraw our February 23, 1999 order. On reconsideration, as supplemented herein, we republish our February 23, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 23, 1999 Cite as 51 Van Natta 462 (1999)

In the Matter of the Compensation of
JEFFREY T. BLANCHARD, Claimant
WCB Case No. 98-05663
ORDER ON RECONSIDERATION
Carney, et al, Claimant Attorneys
Sather, Byerly, et al, Defense Attorneys

The self-insured employer requests reconsideration of our February 23, 1999 order that adopted and affirmed the Administrative Law Judge's (ALJ's) order finding that claimant's bilateral carpal tunnel syndrome claim was prematurely closed. Specifically, the employer reiterates the arguments it made previously on review about the persuasiveness of the medical evidence.[1] Having considered claimant's response (which opposes the employer's motion), we proceed with our reconsideration.

As we explained in our initial order, we rely on Dr. King's opinion because we find it the most persuasive regarding expectations for material improvement in claimant's condition as of the June 4, 1998 Notice of Closure. We continue to find Dr. King's opinion that claimant was not medically stationary at claim closure more persuasive than Dr. Rabies' opinion (that claimant was medically stationary 5 weeks earlier), for several reasons.

First, we note that Dr. King was treating claimant as of claim closure and he offered his opinion closest in time to closure. In addition, as we explained, Dr. King's statement that claimant was not medically stationary, (Ex. 61), together with his prescription for six more weeks of physical therapy, (Ex. 56), indicates to us that Dr. King had a reasonable expectation of further material improvement in claimant's condition with six more weeks of physical therapy. Finally, we find Dr. Rabie's opinion that claimant was medically stationary on April 28, 1998 unpersuasive because it is entirely conclusory.

Accordingly, our February 23, 1999 order is withdrawn. On reconsideration, as supplemented herein, we republish out February 23, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We decline to grant the employer's request to allow "post-abatement" supplemental briefing in this case. The employer has submitted appellant's and reply briefs, as well as arguments with its motion for reconsideration. Under these circumstances, we find that the employer has had an adequate opportunity to present its position.

In the Matter of the Compensation of
DAVID W. MORRISON, Claimant
WCB Case No. 98-03095
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
James P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Marshall's order that awarded an assessed attorney fee of $3,000. On review, the issue is attorney fees.

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

After finding that claimant proved compensability of his right inguinal hernia condition, the ALJ decided that "claimant's counsel is entitled to an assessed attorney fee for prevailing over SAIF's denial. ORS 656.386(1)." The ALJ further stated that, "[i]n awarding the fee below, I have considered the factors set forth in OAR 438-015-0010(4)." The ALJ then ordered SAIF to pay $3,000 as an assessed attorney fee.

On review, SAIF contends that, under *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), the ALJ's order is insufficient with regard to the attorney fee award. Specifically, SAIF contends that the ALJ was required to make findings for each of the factors contained in OAR 438-015-0010(4)[1] and, because the order failed to do so, asks the Board to vacate and remand. Claimant responds that the order is sufficient and that the attorney fee award should be affirmed or increased.

As we have in previous cases, we reject SAIF's argument. It is sufficient for an ALJ to merely describe or cite the rule-based factor or factors upon which the ALJ relied in determining a reasonable attorney fee when the parties at hearing do not dispute or submit argument to the ALJ concerning the weighing of the rule-based factors. *See McCarthy*, 327 Or at 188; *Daryl L. Underwood*, 50 Van Natta 2330 (1998).

Here, SAIF did not (and continues not to) provide any discussion or argument concerning the specific application of the rule-based factors. Because the ALJ indicated that he had considered those factors in assessing the fee, we find the order, as well as the record, sufficient for review. *Jerome O. Johnson*, 50 Van Natta 2412 (1998). Thus, we deny SAIF's motion to remand.

In addition to the ALJ's discussion, we note the following. The hearing transcript is 28 pages long and includes the testimony of two witnesses. The record consists of 34 exhibits; claimant's attorney submitted four of these documents.

The compensability issue was of average complexity. The benefit secured for claimant also appears to be average. Because the medical reports concerning causation were divided, there was a risk claimant's attorney would go uncompensated. Both attorneys were experienced and skillful. Finally, there is no assertion of frivolous issues or defenses.

Based on these factors, especially the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated, we agree with the ALJ that $3,000 is a reasonable attorney fee. Finally, claimant's attorney is not entitled to an attorney fee for defending the attorney fee on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

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

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[1] In determining a reasonable attorney fee, the rule requires the ALJ to consider the following factors: (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 an attorney's efforts may go uncompensated; and (8) The assertion of frivolous issues or defenses.

In the Matter of the Compensation of
JANET F. BERHORST, Claimant
Own Motion No. 99-0030M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable condition. Claimant's aggravation rights expired on July 20, 1986. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of her current worsening.

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.*

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).

In order to satisfy the third *Dawkins* criterion, claimant must first establish that she was willing to work. Failing to demonstrate her willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

SAIF contends that claimant was not in the work force at the time of the current disability.[1] Claimant has submitted a September 30, 1998 affidavit and several doctors' reports in support of her contention that she was in the work force. In her affidavit, she asserts "I would have sought work as soon as released by my doctor in 1998 *** I nonetheless was willing to work throughout 1998, had my compensable medical condition, and my doctor, allowed. *** I remained willing to work, but unable to do so, or to seek work, due to my continued complete restriction from work due to my compensable condition."

Based on claimant's affidavit, we are persuaded that claimant is willing to seek employment. However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force.

In support of her position, claimant submitted two reports from Dr. Van Pett, her attending physician, which attest to claimant's inability to work. On August 31, 1998, Dr. Van Pett stated that she took claimant off work in December 1997 and recommended that claimant stay off work until she recovered from surgery which was scheduled on September 18, 1998. In an October 21, 1998 report, Dr. Van Pett opined that it "would have been futile for [her] to seek work in 1998, because of [her] ongoing problems relating to [her] back condition would have rendered it unrealistic for [claimant] to meet or maintain any work schedule from January through September of 1998."

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[1] In support of its position, SAIF references our August 13, 1998 Second Own Motion Order on Reconsideration which adhered to our prior finding that claimant was not in the work force at the time of her then current disability. In that order, as well as the ones preceding it, the relevant time period for which claimant had to establish that she was in the work force was the time prior to her *December 29, 1997* surgery. While a prior finding does not irrevocably commit a claimant to an "out-of-the-work-force" status for the purposes of workers' compensation benefits, she must show that she was in the work force at the time of the current disability. *See Dean L. Watkins*, 45 Van Natta 1599 (1993). *See also Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990). Here, claimant is seeking reopening based on her *September 18, 1998* surgery.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish she was in the work force is the time prior to her September 18, 1998 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

In our August 13, 1998 Second Own Motion Order on Reconsideration (which adhered to our prior orders), we found that, although claimant had demonstrated her willingness to work, there was no persuasive medical evidence that showed that it would have been futile for her to seek work. As noted previously, those orders pertained to a December 29, 1997 "date of disability." Claimant's current request for own motion benefits relates to a September 18, 1998 "date of disability."

Thus, although probative, our previous findings regarding the "futility" issue concerning claimant's 1997 claim are not determinative. Moreover, based on Dr. Van Pett's most current opinion, we find that claimant has provided persuasive medical evidence demonstrating that she was unable to work at the time of her 1998 worsening and that it would have been futile for her to seek work due to the compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning September 18, 1998, the date claimant was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Penalty and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's allegedly unreasonable delay in processing his own motion claim for temporary disability compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due." SAIF's refusal to pay compensation is not unreasonable if it has a legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras*, 103 Or App 65 (1990).

Claimant first requested that SAIF reopen her own motion claim on September 29, 1998. SAIF did not respond to claimant's request. In October and November 1998, claimant's attorney submitted to SAIF additional medical documentation to support her request. By letter dated January 20, 1999, claimant notified the Board of her September 1998 request to have her own motion claim reopened and SAIF's refusal to process the own motion claim.

On January 25, 1999, we acknowledged receipt of claimant's request for own motion benefits and forwarded it to SAIF for processing pursuant to OAR 438-012-0030. We also requested SAIF's position regarding claimant's request for penalties and attorney fees regarding SAIF's allegedly unreasonable claim processing. On January 26, 1999, we received SAIF's own motion recommendation opposing authorization of temporary disability compensation on the basis that claimant was not in the work force at the time of the current worsening.

OAR 438-012-0030 provides that a carrier is required to submit its own motion recommendation within 90 days of receipt of an own motion claim for temporary disability compensation. OAR 438-012-0001 provides, in part, that a "own motion claim" means a written request by or on behalf of a claimant for temporary disability compensation, where claimant's aggravation rights have expired.

Here, claimant's September 29, 1998 letter and supplementations constitute a written request for reopening of her claim under ORS 656.278. SAIF did not to submit a recommendation to the Board until January 26, 1999, more than four months after claimant's request. By failing to timely submit a recommendation to the Board, SAIF delayed the prompt payment of benefits which are now due. We conclude that this delay was an unreasonable resistance to the payment of compensation. *Thomas L. Abel*, 44 Van Natta 1039, *on recon* 44 Van Natta 1189 (1992); *John D. McCollum*, 44 Van Natta 2057 (1992).

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

However, a penalty may not be assessed under ORS 656.262(10)(a) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. *Wacher Siltronic Corporation v. Satcher*, 91 Or App 654, 658 (1988). At the time claimant requested temporary disability compensation, her claim was closed and could only be reopened under our own motion jurisdiction. When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, a penalty cannot be assessed under ORS 656.262(10)(a). *See Thomas L. Abel, supra; Fredrick D. Oxford*, 42 Van Natta 476 (1990).

On the other hand, where, as here, we find that an insurer has unreasonably resisted the payment of compensation, we may assess an attorney fee even in the absence of amounts of compensation "then due." *See* ORS 656.382(1); *Martinez v. Dallas Nursing Home*, 114 Or App 453 (1992); *Robert E. Cornett*, 45 Van Natta 1567 (1993). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services regarding claimant's request for own motion benefits is $1,000. In reaching this conclusion, we have particularly considered the time devoted to the issue (based on the record and claimant's submission), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Finally, claimant's attorney is also 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.

March 22, 1999 Cite as 51 Van Natta 466 (1999)

In the Matter of the Compensation of
PAM TORIX, Claimant
WCB Case No. C9-00556
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Daniel M. Spencer, Claimant Attorney
Alexander D. Libmann, Defense Attorney

Reviewed by Board Members Moller and Biehl.

On March 3, 1999, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On page 2, number 7, the agreement provides;

"The claim was accepted as non-disabling. As such, the March 25, 1998 Notice of Claim Acceptance constitutes claim closure."

We have previously held that, whether the claim has been accepted as disabling or nondisabling, a notice of acceptance does not constitute closure of a claim. *See Lance J. Thompson*, 49 Van Natta 2052 (1997). Thus, we interpret the CDA as providing that the claim has never been closed. Accordingly, based on that interpretation, we find that the agreement satisfies OAR 438-009-0022(4)(b) (CDA must give a date of the first claim closure, if any).

As interpreted herein, we conclude that the parties' agreement is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' CDA is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CORINNE L. BIRRER, Claimant
WCB Case Nos. 98-01138, 98-01097 & 98-01095
ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

On February 25, 1999, we abated our January 28, 1999 order that upheld the self-insured employer's denials of claimant's current left wrist condition. Claimant requested reconsideration, arguing that the employer's denials did not raise the issue that a separate unrelated condition was being denied and also contending that we failed to adequately consider *Roller v. Weyerhaeuser Co.*, 67 Or App 583, *mod* 68 Or App 743, *rev den* 297 Or 124 (1984). Having considered the employer's response and claimant's reply, we proceed with reconsideration.

Claimant contends that the employer's denials did not raise the issue that a separate unrelated condition was being denied. Claimant asserts that if she had been aware that the employer was raising an issue regarding the case of *Zora Ransom*, 46 Van Natta 1287 (1994), her trial strategy would have been entirely different.

The ALJ indicated that one of the issues raised by the parties was whether the employer's preclosure denials were procedurally valid. (Opinion and Order at 3). The ALJ explained:

> "The carrier contends that the denials at Exhibits 24 and 29 are procedurally proper, citing Charles L. Wallace, 49 Van Natta 52, on recon, 49 Van Natta 472 (1997), aff'd mem 152 Or App 566 (1998), and Zora Ransom, 46 Van Natta 1287 (1994). Claimant on the other hand contends that said denials are procedurally inappropriate, citing Michael C. Leggett, 50 Van Natta 151 (1998), Donna Babcock, 49 Van Natta 2083 (1997), and Roller v. Weyerhaeuser Co., 67 Or App 583, [mod] 68 Or App 743, rev den 297 Or [601] (1984)." (Opinion and Order at 3).

The ALJ's order indicates that the parties had raised the issue of whether the employer's preclosure denials were procedurally valid, which included the issue of whether claimant's current left wrist condition was or was not related to the accepted left wrist condition. On Board review, claimant did not contest the ALJ's summary of the parties' respective positions. Under these circumstances, we find that claimant was adequately apprised of the "*Zora Ransom*" issue at hearing and we find no evidence that she objected.[1] *Compare Fred Meyer, Inc. v. Hofstetter*, 151 Or App 21 (1997) (Board did not abuse its discretion in refusing to consider an issue first raised on Board review).

Claimant also contends that the Board failed to adequately consider *Roller v. Weyerhaeuser Co.*, 67 Or App 583, *mod* 68 Or App 743, *rev den* 297 Or 124 (1984). According to claimant, Dr. Rabie's opinion is that claimant's symptoms, presentation and complaints have remained the same. We disagree.

As we explained in our prior order, Dr. Rabie agreed that he began to doubt that claimant's work activities were the major contributing cause of her problems when her condition did not improve with reduced activities. (Ex. 35-10). He explained that claimant had been off work for a very protracted period of time and had no improvement during her time off. (Ex. 35-12). Dr. Rabie was not even sure that claimant's work activities were a material factor in her current left wrist condition. (*Id.*) Furthermore, he was not certain that claimant still had an underlying tendonitis condition. (Ex. 35-14).

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[1] In her reply brief on reconsideration, claimant contends that she did not agree to address the "*Zora Ransom*" issue, although she acknowledges that the employer cited this case in closing argument. Claimant did not object to this issue at hearing or in her brief on review. Because claimant raises her objection for the first time on reconsideration, we are not inclined to address it at this late date. *See Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994) (Board has discretion whether to address issue raised for the first time in reconsideration request); *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any event, even if we considered the objection, we would reject claimant's contention. In doing so, we would note that parties to a workers' compensation proceeding may, by express or implicit agreement, try an issue that falls outside the express terms of a denial. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990); *Sandra M. Goodson*, 50 Van Natta 1116 (1998).

On reconsideration, we adhere to our previous conclusion that the medical evidence establishes that claimant's current left wrist condition is no longer related, in major or material part, to the accepted left wrist tendonitis/intersection syndrome. *See Joey D. Smalling*, 50 Van Natta 1433 (1998); *Zora A. Ransom*, 46 Van Natta at 1287. We continue to uphold the self-insured employer's denials of claimant's current left wrist condition.

On reconsideration, as supplemented herein, we adhere to and republish our January 28, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 23, 1999 Cite as 51 Van Natta 468 (1999)

In the Matter of the Compensation of
TERESA A. RAY, Claimant
WCB Case No. C9-00498
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jodie P. Polich, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Biehl and Bock.

On February 25, 1999, 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.

Pursuant to OAR 438-015-0052(1), and absent extraordinary circumstances, attorney fees in CDAs are limited to 25 percent of the first $17,500, plus 10 percent of any amount in excess of $17,500. Here, the attorney fee ($750) provided in the CDA ($2,500) exceeded the limitation allowed by OAR 438-015-0052(1) by $125. Because no extraordinary circumstances were included in the CDA justifying a fee in excess of that allowed by the rule, we wrote the parties on March 4, 1999 and requested an addendum to the agreement that either reduced the fee to the maximum allowed by the rule or provided extraordinary circumstances justifying the fee.

The parties submitted an addendum in support of an extraordinary attorney fee, which represents that claimant's counsel devoted additional hours to resolving the claim over a protracted period of time (including meeting with the attending physician). Based on this unrebutted submission, we find sufficient extraordinary circumstances to justify the attorney fee, which is $125 in excess of the $625 maximum fee which would generally be allowed for a $2,500 CDA by the rule. *See* OAR 438-015-0052(1). Accordingly, as clarified by this order, the CDA is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). The parties' CDA, including an extraordinary attorney fee payable to claimant's counsel, 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
ANDREW W. GRIFFIN, Claimant
WCB Case No. 98-04347
ORDER ON REVIEW
Bischoff, Strooband, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that decreased claimant's scheduled permanent disability award for the loss of use or function of the right eye from 45 percent (45 degrees), as awarded by the Order on Reconsideration, to 27 percent (27 degrees). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument on review that the ALJ erred in interpreting the standards by failing to apply subsection (2)(g) of OAR 436-035-0260 in addition to subsections (2)(a) through (e). Claimant reasons that the Director implemented a rule granting an impairment rating for lens removal and implanting a prosthetic lens in addition to a rule granting an award for the effect of the implantation of the lens on the worker's central visual acuity. We do not agree for the following reasons.

We acknowledge that the rule is subject to more than one interpretation. Nonetheless, when analyzed in context, claimant's construction of the regulatory scheme leads to the illogical result of granting a duplicative award for the same impairment that, in some claims, could potentially culminate in a permanent disability award in excess of the statutory maximum under ORS 656.214(2)(h).

Under the application of subsection (2)(g) urged by claimant, he receives a 25 percent value for his lens removal. Yet, under subsection (2)(e), a 25 percent value has already been combined with his central visual acuity loss for his lens removal and prosthetic lens implant. To interpret subsection (2)(g) as providing for a second 25 percent value for the same impairment effectively doubles a worker's disability award for that impairment. Such an interpretation is contrary to the express terms of subsection (2)(e), which specifically provides for "an additional 25%" value to be combined with a worker's central visual acuity. Such a construction of the administrative rule is also inconsistent with specific statements in subsection (2)(g), which provide that "[t]he values below are rounded to nearest whole number *in order to allow for combining with other findings*" and "*the middle figure [is to be] used when the lens is absent and a prosthetic lens has been implanted** * *." (Emphasis supplied.)

Rather than claimant's redundant methodology for calculating his permanent disability, we conclude that subsections (2)(a) through (g) may be more logically interpreted in a way that gives effect to all the subsections, without conflicting with the terms of ORS 656.214(2)(h). Specifically, because subsection (2)(e) has already required that the "lens removal/prosthetic implant" value be "combined" with central visual acuity loss, subsection (2)(g) merely provides a table for assisting parties in calculating those values. This interpretation is consistent with the express terms of subsection (2)(g) that the table "is to be used only when combining central acuity with other visual system impairment, such as lens removal, visual field loss, motility, etc." In other words, the table in subsection (2)(g) is not *awarding* a separate value for an impairment; rather, it is providing a matrix that enables parties, evaluators, and decision makers to "combine" the values that have been identified and granted in the previous subsections of the rule.[1]

In sum, based on the reasoning discussed above, we affirm the ALJ's order that applied only one 25 percent value for claimant's lens removal and prosthetic implant when calculating permanent disability for a monocular vision loss.

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[1] Not only does this construction of the rule fully apply each subsection, but this interpretation does not result in a potential award in a given claim of permanent disability for the partial loss of monocular vision in excess of the 100 degree statutory maximum of ORS 656.214(2)(h). Claimant's application of the rule, in contrast to the method set forth above, could create an award that exceeded 100 degrees. For example, assume that a worker's near vision was limited to 14/80 and distance vision was 20/400. With a lens removal and prosthetic implant, that worker's impairment value would be 91, which would then be combined with another separate 25 percent value under (2)(g) for a total award exceeding 100 degrees. In our interpretation of the rule, that worker would receive a 91 percent award, thus achieving the intentions expressed in each of the subsections.

ORDER

The ALJ's order dated September 24, 1998 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that subsection (2)(g) of OAR 436-035-0260 should not be applied in addition to subsections (a) through (e) of the same rule. Because I believe that claimant has established the presence of greater permanent impairment than that allowed by the majority, I must dissent.

Claimant is entitled to scheduled PPD benefits for partial or complete loss of vision of one eye in that proportion of 100 degrees which the loss of monocular vision bears to normal monocular vision. ORS 656.214(2)(h). In addition, workers with an irreversible finding of impairment due to the compensable condition (here, partial loss of vision) shall receive the full value awarded in these rules for an irreversible finding, which is combined with other permanent impairment caused by the compensable injury. Irreversible findings include lens implant and lensectomy. *See* OAR 436-035-0007(1)(a) and (d).

I agree with the ALJ that claimant should be compensated for the loss of visual acuity by combining the value for central visual acuity (3) with an additional value for lens removal and implantation of a prosthetic lens (25) for a value of 27 for loss in central visual acuity. OAR 436-035-0260(2)(a) through (e). In addition, I would combine this value with the irreversible findings of lens implant and lensectomy (25), for a total value of 45. OAR 436-035-0007(1)(d); 436-035-0260(g). Accordingly, I would reinstate the May 19, 1998 Order on Reconsideration's scheduled permanent disability award for the loss of use or function of the right eye of 45 percent.

In the Matter of the Compensation of
LAURA ALLRED, Claimant
WCB Case No. C9-00661
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Daniel J. DeNorch, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock and Haynes.

On March 16, 1999, 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.

Here, the first page of the proposed agreement provides a total consideration of $7,500. Originally, the agreement provided that claimant would receive $5,625 and claimant's attorney would receive an attorney fee of $1,875 payable out of the CDA proceeds. By handwritten revision, the attorney fee has been reduced to $1,687.50 (see page 1 and 3), thereby increasing the total amount due claimant to $5,812.50. However, the amount payable to claimant has not been revised.

Upon review of the document as a whole, we find that it is the intent of the parties to settle this matter for a total consideration of $7,500, with an attorney fee of $1,687.50 payable to claimant's attorney and $5,812.50 payable to claimant.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $1,687.50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY L. LEDIN, Claimant
WCB Case No. 93-13841
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's right knee condition; and (2) awarded a $13,750 attorney fee under ORS 656.386(1) and ORS 656.388(1). Claimant moves to strike SAIF's brief based on untimely filing. On review, the issues are motion to strike, compensability and attorney fees. We deny claimant's motion and affirm.[1]

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike SAIF's brief based on untimely filing.

Under OAR 438-011-0020(2), a party's appellant brief must be filed within 21 days after the date of mailing of the transcript of record to the parties. "Filing" means the physical delivery of an item to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a).

On December 30, 1998, the Board notified the parties that SAIF had until January 20, 1999 to file its brief. Although SAIF's attorney's certificate of service indicates that SAIF's brief was mailed on January 20, 1999, the postmark on the envelope containing the brief shows a date of January 21.

For purposes of appellate briefs, "filing" may be accomplished by mailing by first class mail, postage prepaid. OAR 438-005-0046(1)(c). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. *Id.* Here, SAIF's attorney included such a certificate with the brief, indicating that a copy of the brief had been mailed to the Board and to claimant's attorney on January 20, 1999, the day the brief was due. Thus, under the applicable administrative rules, SAIF's appellant's brief was timely filed. *See, e.g., Josephine A. Austin*, 50 Van Natta 894 (1998). Consequently, the motion to strike is denied.

Compensability

SAIF requests that we disavow that portion of the ALJ's order that found that SAIF had accepted claimant's neurolemmoma condition. SAIF asserts that the ALJ's finding was not necessary in light of SAIF's concession that claimant's 1976 surgery caused femoral neuropathy in claimant's right leg. SAIF agrees that, because the injury to claimant's femoral nerve occurred during a compensable surgical procedure, the femoral neuropathy is compensable. Because claimant does not object to SAIF's request, we do not adopt that portion of the ALJ's order that found that SAIF had accepted claimant's neurolemmoma condition. We replace the "*Compensability/Acceptance of Neurolemmoma*" section of the ALJ's order with the following:

> "Claimant developed femoral neuropathy in his right leg during surgery in November 1988. SAIF concedes that the injury to claimant's femoral nerve occurred during a compensable surgical procedure and, therefore, the femoral neuropathy is compensable."

We adopt and affirm the ALJ's reasoning and conclusion that claimant's right medial meniscus tear is compensable.

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[1] We modify the ALJ's order to note that Exhibits 19DD and 19DDD, rather than 19BB and 19BBB, were admitted in evidence. We also note that Exhibits 27A, 27B and 27C, rather than "27 through 27A," were admitted in evidence.

Attorney Fees

The ALJ awarded an attorney fee of $13,750 for prevailing against SAIF's denial. The award included $4,250 for claimant's attorney's services at the initial hearing, $1,000 for services on the previous Board review, $3,750 for services at the Court of Appeals, $1,000 for services before the Board on remand and $3,750 for services at the hearings level on remand. The ALJ considered the factors in OAR 438-0015-010(4) in awarding the attorney fee.

SAIF argues that the attorney fee award of $13,750 is excessive given the efforts expended and the results obtained. For the following reasons, we disagree.

Under 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. We determine the amount of claimant's attorney fee for services at the hearing and on review by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The primary issue was whether claimant's right knee condition was compensable. Sixty-nine exhibits were received into evidence, 22 of which were generated or submitted by claimant's counsel. There were no depositions. The June 1, 1995 hearing lasted one hour and 15 minutes. The transcript was 25 pages. Claimant testified on his own behalf.

After the June 1, 1995 hearing, claimant's attorney submitted a two-page letter regarding the issue of SAIF's amended denial, a one-page letter responding to SAIF's June 2, 1995 letter, a three-page closing argument and a two-page reply to SAIF's closing argument. Regarding the June 1, 1995 hearing, claimant's attorney submitted an affidavit stating that he worked 35 hours on the case, requesting an hourly rate of $150 for a total attorney fee of $5,250. The ALJ awarded an attorney fee of $4,250 for services at the June 1, 1995 hearing.

On initial Board review, claimant's attorney submitted a seven-page brief. The Board awarded an assessed fee of $1,000. We note that the attorney fee award for services at the June 1, 1995 hearing ($4,250) and the award for Board review ($1,000) were not previously contested. On review, we find those attorney fee awards reasonable.

Claimant's brief to the Court of Appeals was 12 pages. After the court remanded the case to the Board, *SAIF v. Ledin*, 149 Or App 94 (1997), claimant's attorney submitted a six-page supplemental brief on remand. Claimant's attorney also submitted a two-page response to SAIF's Memorandum of Additional Authority.

The Board remanded the case to the ALJ to consider claimant's motion to continue the hearing based on SAIF's amended denial. *Larry L. Ledin*, 50 Van Natta 115 (1998). Claimant's attorney submitted an eight-page closing argument and a five-page reply brief to the ALJ. One of claimant's attorneys submitted an affidavit requesting assessed fees of $5,775 for his services at the Court of Appeals and $1,080 for services at the Board. Claimant's other attorney submitted an affidavit requesting assessed fees of $8,000 for his services following the first hearing. The ALJ reduced claimant's fee request to $3,750 at the Court of Appeals, $1,000 on remand to the Board and $3,750 for services at the hearing on remand.

We agree with the ALJ's conclusion that this case was complicated legally, although the medical issues were not particularly complicated. We also agree with the ALJ that, although the hearing was not lengthy, the proceedings were prolonged because of the legal issues involved. The value of the interest involved and the benefit to claimant are substantial, in that claimant has had surgery for his right knee condition. In light of the contradictory medical opinions, there was a risk that claimant's counsel might go uncompensated. Finally, claimant's attorneys and defense counsel are skilled litigators with substantial experience in workers' compensation law, and no frivolous issues or defenses were raised. Considering all these factors, we agree with the ALJ that an attorney fee of $13,750 is reasonable for services at hearing, Board review, judicial review and remand (before the Board and the ALJ). Claimant is not entitled to an attorney fee for services expended in securing the attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,500, payable by SAIF. We note that claimant's attorney submitted an 11-page brief on review and a two-page motion to strike SAIF's brief, as well as an affidavit in support of an attorney fee. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's attorney's affidavit and respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue and his unsuccessful motion to strike.

ORDER

The ALJ's order dated December 1, 1998, as amended December 17, 1998, is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
LEONARD E. LOW, Claimant
Own Motion No. 98-0478M
OWN MOTION ORDER ON RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

On January 20, 1999, we withdrew our December 23, 1998 Own Motion Order that declined to reopen claimant's 1992 claim for the payment of temporary disability compensation. We took this action to consider claimant's submission of additional information regarding the issue of whether he was in the work force at the time of his current disability. Having received the insurer's response and completing our reconsideration, we withdraw our prior order and replace it with 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).

On August 11, 1998, Dr. Bynum, claimant's attending physician, noted that claimant could not work and that it would have been futile for him to look for work because of his compensable condition. Concluding that claimant was not capable of continuing his job as a janitor, Dr. Bynum observed that only with appropriate work restrictions and possible vocational rehabilitation claimant "should be employable in a more sedentary job."

Based on this unrebutted opinion, we find that claimant was unable to work at the time of his current worsening and that, without certain work accommodations and vocational assistance, it would have been futile for him to seek work due to the compensable condition. Thus, the "futility standard" of the third *Dawkins* criterion has been satisfied.[1]

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[1] Additionally, the insurer acknowledges that claimant is willing to work and that it is futile for him to seek work due to his work related injury.

In order to satisfy the third *Dawkins* criterion, claimant must also establish, that he was willing to work. Failing to demonstrate his willingness to work, then he is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted a January 15, 1999 affidavit stating that he worked in June and July 1998, but quit because of pain in his knee. He declares that he is willing to work, but has been unable to do so due to his work related injury. Based on claimant's unrebutted statements, we find that he has demonstrated his willingness to work at the time of his current disability.

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
STEVE PULLEN, Claimant
WCB Case No. 98-05520
ORDER ON REVIEW
Richard M. Walsh, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that awarded a $3,500 assessed attorney fee under ORS 656.386(1) for claimant's counsel's services at hearing. SAIF also moves for remand. On review, the issue are attorney fees and remand

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

The ALJ awarded claimant's attorney an assessed fee of $3,500. SAIF argues that the ALJ erred in failing to apply each of the factors in OAR 438-015-0010(4) and in failing to make specific findings of fact in regard to each factor in determining the amount of the attorney fee.[1] SAIF requests that we remand the case to the ALJ to make reviewable findings supporting the attorney fee award.

We considered similar arguments 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 Supreme Court's decision in *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recon* 327 Or 185 (1998), 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. Based on our reasoning in *Underwood*, we continue to hold that the ALJ need not make findings for each rule-based factor.

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[1] SAIF does not contend that the ALJ's attorney fee award was excessive.

Here, however, the ALJ simply ordered SAIF to pay "an assessed fee of $3,500" for services in setting aside the denial. Because the ALJ did not describe or cite the specific factor or factors within OAR 438-015-0010(4), we agree with SAIF that the ALJ did not provide reasoning sufficient for review. *See Carol E. Brown*, 51 Van Natta 58 (1999). Nevertheless, because we are authorized to modify or supplement the ALJ's order under ORS 656.295(6), it is not necessary to remand this case to the ALJ for supplementation 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 2330.

In determining a reasonable attorney fee, we consider the following factors: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses. OAR 438-015-0010(4).

The record contains no statement of services documenting the time claimant's attorney spent on the case. The issue was compensability of claimant's back injury. The hearing lasted 1 hour and 20 minutes, which included 30 pages of transcript. Claimant testified on his own behalf. SAIF presented the testimony of one witness. The record contains 22 exhibits, five of which were submitted by claimant's attorney.

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. Because claimant's back 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 parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, in light of the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone 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 $3,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the value of the interest involved, and the risk that counsel may go uncompensated.[2]

ORDER

The ALJ's order dated December 1, 1998 is affirmed.

[2] 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, *rev den* 302 Or 35 (1986).

March 24, 1999 Cite as 51 Van Natta 475 (1999)

In the Matter of the Compensation of
JOSEPH C. SHOULTZ, Claimant
Own Motion No. 99-0023M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable lumbosacral strain injury. Claimant's aggravation rights expired on August 20, 1991. SAIF opposes the reopening of the claim on the grounds that: (1) no surgery or hospitalization has been requested; (2) surgery or hospitalization is not reasonable and necessary; and (3) claimant is not in the work force.

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

In response to SAIF's contentions, claimant submitted copies of his 1996 and 1997 W-2 forms and medical documentation. Yet, the record contains no request for surgery or any indication that claimant has undergone surgery. Although Dr. Dunn, claimant's attending physician, has recommended that claimant received a spinal cord stimulator, there is no indication that application of the spinal cord stimulator requires surgery.[1]

Claimant also alleges that he was hospitalized on July 28, 1998. A review of the hospital chart note reveals that, although claimant was examined and a lengthy history and physical was taken, there were no procedures done on that day which involved inpatient or outpatient surgery. Further, because there were no procedures undertaken on that day which required an overnight stay, we do not regard this visit to the hospital as "hospitalization" sufficient to justify claim reopening. *Fred E. Smith, supra.*[2]

Accordingly, the record submitted to us fails to demonstrate that claimant has undergone or requires surgery or hospitalization in the near future. As a result, we are not authorized to grant claimant's request to reopen the claim. Therefore, we deny the request for own motion relief. *Id.*

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] We interpret "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).

[2] Inasmuch as we have concluded that claimant's claim does not met the "worsening" criteria of ORS 656.278(1)(a), we need not address the work force issue at this time.

March 24, 1999 Cite as 51 Van Natta 476 (1999)

In the Matter of the Compensation of
JOHN WIKSTROM, Claimant
Own Motion No. 98-0207M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Linerud Law Firm, Claimant Attorneys
Saif Legal Department, Defense Attorney

On May 29, 1998, we declined to reopen claimant's claim for the payment of temporary disability compensation because the disputes surrounding the compensability of claimant's current condition and work force status remained unresolved. Thereafter, claimant requested reconsideration of our order and submitted additional information regarding his work force status.

We abated our May 29, 1998 order and allowed the SAIF Corporation time to respond to claimant's request for reconsideration. In response, SAIF submitted a copy of its July 22, 1998 denial of the compensability of claimant's current need for C4-5 discectomy/fusion condition. Claimant requested a hearing regarding that denial. (WCB Case No. 98-07522).

On November 3, 1998, we referred this Own Motion matter to the Hearings Division for consolidation with the litigation pending before the Hearings Division. At the conclusion of that litigation, the ALJ was requested to submit a recommendation regarding claimant's request for Own Motion relief.

On January 7, 1999, the ALJ issued an Order of Dismissal. In doing so, the ALJ found that claimant's hearing request had been withdrawn. The ALJ's dismissal order has not been appealed.

Asserting that the condition on which claimant's surgery is based is not compensable, SAIF seeks reinstatement of our May 29, 1998 order that denied reopening of claimant's "Own Motion" claim. On February 23, 1999, we forwarded a copy of SAIF's January 22, 1999 letter requesting an Own Motion order denying reopening to claimant and requested his written response to SAIF's contentions within 14 days from the date of the letter. Inasmuch as the 14 day period has expired, we have proceeded with our review.

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

Here, claimant's hearing request regarding SAIF's denial of his claim has been dismissed. That Order of Dismissal has not been appealed. Thus, the compensability for claimant's current condition and need for surgery remains in denied status. Under such circumstances, we are not authorized to reopen claimant's claim. Accordingly, claimant's request for temporary disability compensation is denied.

IT IS SO ORDERED.

March 25, 1999 Cite as 51 Van Natta 477 (1999)

In the Matter of the Compensation of
ANNA R. ARCIERO, Claimant
WCB Case No. 96-10188
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Biehl and Moller.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) denied her request to continue the hearing for admission of a "post-hearing" nerve conduction study; and (2) upheld the insurer's denial of her aggravation claim for a left carpal tunnel condition. With her appellant's brief, claimant has submitted a medical report not admitted into the record at the time of hearing. We consider claimant's submission as a motion for remand. In its brief, the insurer moves to strike a portion of claimant's brief because it refers to "post-hearing" events.[1] On review, the issues are remand and aggravation. We deny the motion for remand and affirm.

FINDINGS OF FACT

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

In 1993, the insurer accepted claimant's occupational disease claim for disabling left carpal tunnel syndrome. The claim was closed on September 30, 1993, with no award of permanent disability.

On July 19, 1996, claimant returned to Dr. Grossenbacher, her attending physician, with complaints of discomfort in her hands. Grossenbacher did not think nerve conduction studies were appropriate at that time and filed a Notice of Claim for Aggravation accompanied by his examination notes. The insurer neither accepted nor denied the claim. On November 13, 1996, claimant filed a request for hearing on the insurer's "de facto" denial of her aggravation claim. A hearing was scheduled for February 5, 1997.

On January 29, 1997, the insurer requested a postponement; the hearing was reset for June 20, 1997.

Meanwhile, on June 16, 1997, claimant returned to Dr. Grossenbacher for followup. He noted that she continued to be symptomatic in both wrists, and felt it would be appropriate to repeat nerve conduction studies to compare them with those of 1993.

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[1] Claimant's brief is based, in part, on a document that was not admitted into evidence. Our review must be based on the record certified to us. *See* ORS 656.295(5). To the extent that claimant's brief discusses medical opinion not in the record, we treat it as a motion to remand to the ALJ for the taking of additional evidence. The document not admitted, but presented on review along with arguments, has been considered solely for the purposes of the remand issue. Therefore, we deny the insurer's motion to strike.

On June 19, 1997, claimant requested a postponement because she was no longer represented by counsel on that date. The hearing was reset for February 6, 1998.

On July 7, 1997, claimant's current attorney advised that he was representing claimant.

On September 5, 1997, claimant sought treatment from Dr. Fields for multiple issues, including carpal tunnel syndrome. She reported that her treating surgeon wanted to get new nerve conduction studies. On September 31, 1997, Dr. Fields gave claimant braces for both wrists, stating that nerve conduction studies would be considered if her condition did not improve with the braces.

On February 5, 1998, claimant's counsel requested postponement of the hearing because claimant had been hospitalized with chest pains; the hearing was reset for July 27, 1998.

On February 20, 1998, claimant's counsel wrote to the insurer noting that Grossenbacher's nerve conduction studies had not taken place. On July 16, 1998, the insurer authorized Grossenbacher's request.

At the July 27, 1998 hearing, claimant had not received the requested nerve conduction study report, which was scheduled for August 5, 1998. The ALJ denied claimant's motions to leave the hearing record open for the admission of the report both at hearing and on reconsideration on the basis that claimant had not established "extraordinary circumstances" for her request.[2] The ALJ then found that claimant's condition had not worsened and upheld the insurer's denial.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, claimant has submitted the nerve conduction study with her brief and renewed her argument that the nerve conduction study report should be admitted into the record. We treat claimant's submission as a motion for remand and deny the motion.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995). However, we need not resolve the issue of whether the ALJ abused his discretion in declining to admit the document in question because, as discussed below, the result would not change even if that document were considered.

We may remand to the ALJ for the taking of additional evidence if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is generally appropriate only upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable with due diligence at the time of the hearing; and (3) is reasonably likely to affect the outcome. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

The issue before us is whether claimant has established a compensable aggravation since the last award or arrangement of compensation. ORS 656.273(1). A compensable aggravation is established by medical evidence of a pathological worsening of the compensable condition supported by objective findings. *Id.*; *SAIF v. Walker*, 145 Or App 294, 305 (1996).

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[2] Claimant's motion was apparently made prior to going on the record at hearing. At hearing, the ALJ referred to claimant's motion as a motion for "postponement" (Tr. 3, 5, 6), an "offer of proof " (Tr. 5), and a request "to keep the record open for the development of additional medical evidence" (O&O at 1). The issue as raised by claimant on review is the ALJ's failure to reopen the record for admission of the nerve conduction study that took place after the hearing. We interpret claimant's initial request as a motion for continuance of the hearing for admission of the "post-hearing" nerve condition study and we review the ALJ's decision for abuse of discretion. *E.g., David E. Collins*, 49 Van Natta 561 (1997) (distinguishing between standards to be applied in analyzing motion for continuance and motion for postponement). *See also Herbert Gray*, 49 Van Natta 714 (1997).

The document submitted by claimant on review is Dr. Cobasko's report of the result of nerve conduction studies conducted on November 5, 1998. Although this document arguably establishes "objective findings" regarding claimant's left carpal tunnel condition, it does not address whether claimant's condition has pathologically worsened. Thus, it is not reasonably likely to affect the outcome of this case. Accordingly, we conclude that remand is not warranted. The motion to remand is denied.

Aggravation

We adopt and affirm the ALJ's opinion with the following supplementation. The record does not support a conclusion that claimant's condition has worsened since the last award or arrangement of compensation. *See* ORS 656.273(1).

ORDER

The ALJ's August 18, 1998 order, as reconsidered November 27, 1998, is affirmed.

March 25, 1999 Cite as 51 Van Natta 479 (1999)

In the Matter of the Compensation of
THOMAS D. DUNBAR, Claimant
WCB Case No. 98-05736
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's current lumbar spondylolisthesis condition. On review, the issue is compensability.

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

On review, the employer contends claimant has not carried his burden of proving a pathological worsening pursuant to ORS 656.225(1). We have previously held that the application of ORS 656.225 is limited by its terms, to "disability caused by or medical services solely directed to a worker's preexisting condition. *E.g., Anne M. Walker*, 49 Van Natta 600 (1997); *Linda F. Hansen*, 48 Van Natta 2560 (1996). Therefore, where a worker's disability or need for medical services was caused by a "combined condition," *i.e.*, the combination of a preexisting condition and the compensable injury, we have held that the provisions of ORS 656.225(1) are not germane to the compensability issue. *E.g., Mitchell J. Thompson*, 50 Van Natta 289, 291 n. 3 (1998); *Anne M. Walker*, 49 Van Natta at 600; *Paul E. Hargreaves*, 48 Van Natta 1676, 1677 (1996).

Here, the medical evidence is in agreement that the work injury combined with claimant's preexisting spondylolisthesis. (Exs. 7, 8, 14A, 15-17). Consequently, ORS 656.225(1) is not applicable.

Claimant's attorney is entitled to an assessed attorney fee for services related to the compensability issue on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and apply them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] In his respondent's brief, claimant, for the first time, challenges the employer's denial on the basis that it is procedurally invalid. Because this issue is being raised for the first time on review, we are not inclined to address it. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). Moreover, because claimant proceeded to litigate the merits of the compensability, without raising the procedural issue, it is questionable whether that issue has been preserved. *See Thomas v. SAIF*, 64 Or App 183 (1983). In any event, claimant has prevailed on the merits of the employer's denial so the procedural validity of the employer's denial is not determinative.

ORDER

The ALJ's order dated October 30, 1998 is affirmed. For services on review, claimant's counsel is awarded $1,200, as a reasonable assessed attorney fee, payable by the self-insured employer.

March 25, 1999 Cite as 51 Van Natta 480 (1999)

In the Matter of the Compensation of
ROSALIE W. KARALEKAS, Claimant
WCB Case No. 98-05822
ORDER ON REVIEW
Ralph E. Wiser III, Claimant Attorney
Mannix, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's occupational disease claim for bilateral plantar fascitis. In her brief, claimant requests sanctions against the employer's attorney for an allegedly frivolous appeal. On review, the issues are compensability and sanctions.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's request for sanctions based on the employer's allegedly frivolous request for review. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2).

Here, the employer has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the argument on review did not ultimately prevail, we cannot say it is "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

Claimant's attorney is entitled to an 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 $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 3, 1998, as republished December 8, 1998, is affirmed. For services on review, claimant is awarded a $750 attorney fee, payable by the self-insured employer.

In the Matter of the Compensation of
BARBARA C. AVEDOVECH, Claimant
WCB Case No. 97-07190
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's aggravation claim for a reactive airways disease (asthma) condition. On review, the issue is aggravation.

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

The third to the last paragraph of the findings of fact should read as follows. "As a result of the acute exacerbation of claimant's reactive airways disease, she was unable to work for six days. (Tr. 19)."

ORS 656.273(1) provides, in relevant part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings."

After the ALJ's order issued and claimant submitted her appellant's brief, the court issued its decision in *Intel Corporation v. Renfro*, 155 Or App 447, 450 (1998), in which it found that "the 1995 amendment to ORS 656.273(1) did not 'legislatively overrule' [the holding in *Smith v. SAIF*, 302 Or 396 (1986)] that, to establish a compensable aggravation of an unscheduled condition, a claimant must prove that the worsening of the condition resulted in diminished earning capacity." Thus, to prove a compensable aggravation of an unscheduled condition, a claimant must prove both of the following two elements: (1) an "actual worsening" of that condition, *SAIF v. Walker*, 145 Or App 294, 305 (1996); (2) that results in diminished earning capacity. *Renfro*, 155 Or App at 452-53. Because we agree with the ALJ's reasoning and conclusion that claimant did not establish an "actual worsening" of her asthma condition, we need not address the issue of whether she established a diminished earning capacity.

As the ALJ found and the parties agree, only Dr. Olenick, treating physician,[1] provides an opinion as to whether claimant sustained an "actual worsening" of her compensable asthma condition. ORS 656.273(1). In his deposition, Dr. Olenick explained that the underlying condition in asthma is the tendency towards getting bronchial spasms. (Ex. 33-21). He also stated that the only way to differentiate between a temporary worsening and a permanent worsening of this underlying tendency towards bronchial spasm is to observe the patient over time. (Ex. 33-21-22). He explained that in order to establish a pathological worsening of the underlying asthma condition, he would need to see a pattern develop over time that would include the following factors: (1) more frequent asthma attacks; (2) more severe attacks; and (3) changes in medication needs, with the need for higher doses of medication to control the condition and/or previously effective medication becoming ineffective. (Ex. 33-24).

Nonetheless, Dr. Olenick did not opine that claimant had experienced those factors. Instead, in both his deposition and his written opinions, Dr. Olenick repeatedly opined that claimant's acute asthma attack in May 1997 represented a waxing and waning of her symptoms, without any pathological worsening of her underlying condition. (Exs. 29, 31, 32, 33-11, -17, -22, -23, -24).

On review, claimant argues that the record shows that she experienced the above three factors that Dr. Olenick explained would establish a pathological worsening of an underlying asthma condition. Therefore, claimant argues, she has established the necessary pathological worsening. We disagree.

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[1] Dr. Olenick saw claimant twice and reviewed her medical records. (Exs. 24, 31, 32, 33).

Whether claimant established a pathological worsening of her underlying asthma condition is a medical question that must be answered by expert medical opinion. Neither claimant nor we are qualified to independently analyze the medical record and determine that the elements of a pathological worsening have been met. This is especially true when the very medical expert who defined those elements concluded that claimant did *not* sustain a pathological worsening. (Exs. 29, 31, 32, 33-11, -17, -22, -23, -24). Accordingly, after our "de novo" review, we agree with the ALJ that Dr. Olenick's opinion does not satisfy claimant's burden of proving an "actual worsening."

ORDER

The ALJ's order dated March 26, 1998 is affirmed.

Board Member Biehl dissenting.

The majority concludes that claimant failed to prove an "actual worsening" pursuant to ORS 656.273(1), finding that the medical record does not establish that claimant experienced a pathological worsening. I disagree and find that claimant established a temporary pathological worsening of her compensable asthma condition, which I conclude is sufficient to establish an "actual worsening" under ORS 656.273(1). Nevertheless, given the *Renfro* court's subsequent holding that a worker must also prove that the "actual worsening" resulted in a "diminished earning capacity" in order to prove a compensable aggravation claim, I would ultimately conclude that the record is insufficiently developed to determine whether claimant's aggravation claim is compensable. *Intel Corporation v. Renfro,* 155 Or App 447, 450 (1998). Therefore, I would remand the matter to the ALJ for further proceedings regarding whether claimant sustained a "diminished earning capacity" as a result of her actual worsening. Because the majority reaches a different conclusion, I respectfully dissent.

Claimant is a registered nurse who developed respiratory symptoms when she was exposed to strong fumes at work on July 2, 1994. Ultimately, the insurer accepted a claim for "reactive airways disease secondary to noxious fumes." Due to her compensable asthma condition, claimant could not tolerate the fumes in the hospital and was transferred to a job exclusively performing home care. Claimant's claim was closed on March 27, 1996. She was ultimately awarded 10 percent unscheduled permanent disability.

On May 14, 1997, claimant was exposed to traffic fumes while performing her home health care duties. As a result of that exposure, she had a severe episode of asthma requiring medical treatment, and she was unable to work for six days. Thereafter, claimant returned to her home health care work. By June 6, 1997, claimant's asthma condition was stable.

Under ORS 656.273(1), "[a] worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." An "actual worsening" may be established by direct medical evidence of a pathological worsening, or for a symptomatic worsening to constitute an "actual worsening," a medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened. *SAIF v. Walker,* 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997).

Here, Dr. Olenick, claimant's treating physician, provides the only medical opinion regarding whether claimant sustained an aggravation of her compensable asthma condition. (Exs. 29, 31, 32, 33). Dr. Olenick initially agreed with a statement from the insurer that claimant only had a waxing and waning of symptoms of her upper respiratory condition about May 1, 1997, without a pathological worsening of the underlying condition. (Exs. 21, 29). Dr. Olenick also reported that claimant was in acute respiratory distress when he saw her on May 14, 1997, although her presentation did not represent any permanent worsening of her condition, nor did it cause underlying structural anatomic change in her respiratory system. (Ex. 31-1). Nevertheless, Dr. Olenick opined that claimant suffered an aggravation of her underlying condition, on a temporary basis. (*Id.*). Finally, in a conversation summary, Dr. Olenick agreed that claimant's need for treatment in May and June 1997 represented a waxing and waning of her symptoms without a pathological worsening of her underlying condition. (Ex. 32-1).

During his deposition, Dr. Olenick more thoroughly explained his opinion. (Ex. 33). Dr. Olenick saw claimant twice and reviewed her medical records. Because of his brief contact with claimant, Dr. Olenick explained that he could tell very little about any chronicity or permanency regarding claimant's problem. (Ex. 33-7). Furthermore, he explained that he considered "pathological" to imply a permanent change, or a structural change in the body, which is usually of a permanent nature. (Ex. 33-18, -20). Therefore, he explained that by his earlier written statements regarding a lack of pathological changes, he meant that claimant experienced a temporary, not a permanent change. (Ex. 33-17-20).

On the other hand, Dr. Olenick provided a detailed explanation of the physical changes caused by claimant's acute asthma attack. He explained that asthma is the tendency to get bronchial spasms, but an acute asthma attack is an actual bronchial spasm, during which a person cannot breath. (Ex. 33-8-9). Pathologically, during an acute asthma attack the muscles of the bronchial tubes contract and resistance to air movement increases. (Ex. 33-10). In addition, mucus production increases, which also blocks the airway. (*Id.*). Dr. Olenick explained that this was claimant's condition when he first saw her. (*Id.*). During her severe asthma attack, claimant had a temporary worsening of her underlying condition that included, pathologically and objectively, constriction of her bronchial tubes and increased mucus production that made it difficult for her to breath, although there was no permanent worsening of her underlying asthma condition. (Ex. 33-11-13, -17, -22).

I would find that Dr. Olenick's opinion read as a whole establishes that claimant experienced a temporary pathological worsening of her compensable asthma condition during her severe asthma attack in May 1997. Furthermore, I would find that Dr. Olenick's opinion establishes that this worsening is supported by objective findings, *i.e.*, constricted bronchial tubes and increased mucus production. The question remains, however, whether a *temporary* pathological worsening of claimant's compensable condition constitutes an "actual worsening" under ORS 656.273(1)(a). *SAIF v. Walker*, 145 Or App at 305. Based on the following reasoning, I would find that it does.

ORS 656.273(1)(a) states that "an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury" and defines "a worsened condition" in terms of "medical evidence of an actual worsening of the compensable condition supported by objective findings." In interpreting a statute, the first task is to discern the legislature's intent. ORS 174.020; *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). In attempting to discern the intent of the legislature, the first level of analysis is to examine the text and context of the statute. 317 Or at 610-11. If the legislative intent is not clear from that inquiry, the legislative history or other extrinsic aids are examined. *Id.* at 611-12.

After examining the text and context of the language "actual worsening of the compensable condition" in ORS 656.273(1)(a), the *Walker* court determined that that language was sufficiently ambiguous to require examination of legislative history to determine the legislature's intent. 145 Or App at 300. After examining the legislative history, the court determined that the legislature's use of the terms "actual worsening" required proof of a pathological worsening and, "in order for a symptomatic worsening to constitute an 'actual worsening,' a medical expert must conclude that the symptoms have increased to the point that it can be said that the *condition* has worsened." *Id.* at 305 (emphasis in original).

Nevertheless, the *Walker* court's interpretation of "actual worsening" did not include determining whether the legislature intended an "actual worsening" to include a *temporary* pathological worsening. Furthermore, neither the text nor the context of ORS 656.273(1)(a) demonstrates whether the legislature intended an "actual worsening" to include a *temporary* pathological worsening. Thus, like the *Walker* court, I find that the text and context of ORS 656.273(1)(a) does not demonstrate the legislature's intent in defining an "actual worsening." Accordingly, I must resort to legislative history.

Although *Walker* did not specifically address the issue presented here, the legislative history examined in *Walker* is helpful in resolving the current issue. Specifically, the following quote from Representative Mannix[1] is directly on point:

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[1] Representative Mannix, a co-sponsor of Senate Bill 369, the legislation amending ORS 656.273(1), testified before the Senate Labor and Government Operations Committee concerning *amended* ORS 656.273(1).

> "Well to be frank about it, the attending physician will tend to err on the side of caution and say well, looking at this * * * and evaluating this condition, yeah it's worse. *Is it temporarily worse or permanently worse? That doesn't matter. If it's a worsened condition you'll get an aggravation.* Then later you can look at whether its permanent or temporary and reevaluating [*sic*] it. Oh they got better again, fine. They didn't get better, then you got some more permanent disability." *Walker*, 145 Or App at 303-04 (emphasis added).

Moreover, the *Walker* court noted that there did not appear from the legislative history to have been any comment made in response to the legislative history it relied on, which included the above quote from Representative Mannix. *Id.* at 305. Thus, I conclude that the legislative history establishes that the legislature intended a temporary pathological worsening to be sufficient to establish an "actual worsening" under ORS 656.273(1)(a). Therefore, I find that claimant has established an "actual worsening."

The insurer argues that, even if claimant established an "actual worsening," she must also prove that her worsening is more than simply waxing and waning of symptoms of her asthma condition contemplated by the last permanent disability award. The insurer cites ORS 656.214(7) for this proposition. ORS 656.214(7) relates to permanent partial disability, and provides that "[a]ll permanent disability contemplates future waxing and waning of *symptoms* of the condition. The results of waxing and waning of *symptoms* may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization." (Emphasis added). ORS 656.273(8) relates to waxing and waning expressly in the context of aggravation claims.

ORS 656.273(8) provides:

> "If the worker submits a claim for aggravation of an injury or disease for which permanent disability has been previously awarded, the worker must establish that the worsening is more than waxing and waning of *symptoms* of the condition contemplated by the previous permanent disability award." (Emphasis added).

Claimant was previously awarded 10 percent unscheduled permanent disability compensation for her compensable asthma condition. (Ex. 20). Nevertheless, by their terms, ORS 656.214(7) and 656.273(8) do not apply to claimant's aggravation claim. In this regard, I have determined that claimant has sustained a *pathological* worsening of her compensable condition. There is a fundamental difference between "pathology" and "symptoms." Specifically, whereas pathology[2] deals with *structural and functional changes* in tissues and organs of the body, symptoms[3] deal with *subjective evidence* of a condition. Thus, by definition, a *pathological worsening* is more than waxing and waning of *symptoms* of the condition. Therefore, because ORS 656.214(7) and 656.273(8) deal with only waxing and waning of *symptoms*, they necessarily do not apply to claimant's aggravation claim.[4] Accordingly, I would find that claimant has established an "actual worsening" of her compensable asthma condition.

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[2] "Pathological" pertains to "pathology," which is defined as:

"1. that branch of medicine which treats of the essential nature of disease, especially of the structural and functional changes in tissues and organs of the body which cause or are caused by disease. 2. the structural and functional manifestations of disease." *Dorland's Illustrated Medical Dictionary*, 1243, 1244 (28th ed. 1994).

[3] "Symptom" is defined as:

"any subjective evidence of disease or of a patient's condition, *i.e.*, such evidence as perceived by the patient; a noticeable change in a patient's condition indicative of some bodily or mental state." *Dorland's Illustrated Medical Dictionary* at 1620.

[4] I reject any argument that my decision that ORS 656.214(7) and 656.273(8) do not apply to the facts of this case essentially renders those statutes ineffective. As the *Walker* court held, a symptomatic worsening can constitute an "actual worsening," if a medical expert concludes that the symptoms have increased to the point that it can be said that the condition has worsened. 145 Or App at 305. Thus, where the "actual worsening" is established by such a symptomatic worsening, the provisions of ORS 656.214(7) and 656.273(8) dealing with symptomatic waxing and waning would apply. Thus, my interpretation of ORS 656.214(7) and 656.273(8) does not render those statutes ineffective.

Nonetheless, as discussed above, the court has determined that, in addition to establishing an "actual worsening" of the compensable condition, claimant must also prove that this "actual worsening" caused a diminished earning capacity. *Renfro*, 155 Or App at 452-53.

Claimant contends that, because *Renfro* issued after the hearing process was completed and her appellant's brief had been submitted, she was not afforded the opportunity to present evidence or argument regarding the issue of diminished earning capacity. Therefore, claimant requests remand to the Hearings Division for further proceedings.

Under the facts of this case, I would find remand appropriate. The Board may remand a case for further evidence taking if it finds that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Furthermore, a compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. *Troy Shoopman*, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); *Betty S. Tee*, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term).

Here, the legal standard for proving a compensable aggravation claim changed while Board review of a case was pending. Under case law before the 1995 amendments, the phrase "worsened condition" in *former* ORS 656.273(1) was defined as a symptomatic or pathological worsening which resulted in either loss of earning capacity, in the case of an unscheduled condition, or loss of use or function, in the case of a scheduled condition. *See Smith v. SAIF*, 302 Or at 401-02; *Fred Meyer, Inc. v. Farrow*, 122 Or App 164 (1993). Thus, in order to establish a compensable aggravation, a claimant not only had to establish a physical worsening, but also prove that the physical worsening had caused diminished earning capacity or increased loss of use or function.

Following enactment of the 1995 amendments, the Board held that the amended version of ORS 656.273(1) no longer required a claimant to prove diminished earning capacity in order to establish a worsened condition involving an unscheduled body part. *Jason S. Palmer*, 48 Van Natta 2394 (1996).

The standard established in *Palmer* was in effect during the hearing regarding the present case. While Board review of this matter was pending, however, the court issued its decision in *Renfro*, which overruled our decision in *Palmer* and determined that, to prove a compensable aggravation of an unscheduled condition, a claimant must establish an actual worsening of that condition *that results in diminished earning capacity*. *Renfro*, 155 Or App at 452-53. Thus, the *Renfro* court reinstated the requirement of proving a diminished earning capacity in the context of proving an aggravation of an unscheduled condition.

In light of the fact that the record in this case was developed under the lesser standard announced in *Palmer*, I would find that the parties lacked the opportunity to generate evidence regarding whether claimant has sustained a "diminished earning capacity" as a result of the actual worsening of her unscheduled asthma condition. Thus, I would find the record to be incompletely and insufficiently developed to determine whether claimant sustained a compensable aggravation claim. Moreover, given the change in the legal standard while Board review of this matter was pending, I would find that there is a compelling reason to remand this matter to the ALJ.

Accordingly, I would vacate the ALJ's order upholding the insurer's aggravation denial and remand the matter to the ALJ for further proceedings regarding whether claimant sustained a "diminished earning capacity" as a result of the actual worsening of her unscheduled asthma condition.

In the Matter of the Compensation of
JAMES M. DAVIS, Claimant
WCB Case No. 98-05848
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

In upholding SAIF's denial, the ALJ rejected claimant's argument that he could prove the compensability of his 1997 occupational disease claim for low back degenerative disc disease by showing that his 15 year work history, combined with an accepted 1992 low back injury, was the major contributing cause of his low back condition. In doing so, the ALJ observed that claimant had failed to contest a December 1996 denial of an aggravation claim and his then-current condition consisting of degenerative disc disease. Finding that there was no medical opinion addressing whether claimant's condition had changed after the December 1996 denial, nor one that had addressed the cause or causes of his low back condition since that time, the ALJ held that claimant could not prevail on his occupational disease claim.

On review, claimant makes several contentions. He asserts that SAIF never raised the issue of the legal effect of the 1996 denial and that the ALJ mistakenly based her decision on that ground. Citing *Kepford v. Weyerhaeuser*, 77 Or App 363 (1986), claimant also argues that his 1992 injury and pre-December 1996 work exposure can be considered as causal factors in his current occupational disease claim. Finally, claimant asserts that, when the entire record is considered, he sustained his burden of proving a compensable occupational disease claim.

We need not, and do not, address claimant's arguments regarding the scope of the issues and preclusive effect, if any, of the uncontested 1996 denial. That is, even if we considered, as claimant requests, his entire work history, including the compensable 1992 low back injury, as a causal factor, we would not find claimant's 1997 occupational disease claim compensable. We reason as follows.

Claimant's occupational disease claim is for degenerative disc disease. 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), 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). *See Dan D. Cone*, 47 Van Natta 1097, *on recon* 47 Van Natta 2220, *on recon* 47 Van Natta 2343 (1995). 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).

Two physicians recently expressed opinions on the causation issue. Claimant's current attending physician, Dr. Goodwin, opined in January 1998 that claimant had continued low back pain with chronic degenerative disc disease at L4-5 and L5-S1. (Ex. 97). Dr. Goodwin stated that claimant's main symptoms of back pain were related to disc degeneration. *Id.* Dr. Goodwin later opined that claimant's work activities over a 15 year period caused a progressive and accelerated "wear and tear" on his back. (Ex. 99). But, in a September 29, 1998 report, Dr. Goodwin concluded that, while it did pathologically worsen any degenerative disease, claimant's 15 year work history was probably not the major contributing cause of his degenerative disc disease and was not the major contributing cause of his need for treatment. (Ex. 111).

Dr. James, a physician who evaluated claimant's low back condition on behalf of SAIF, concluded that claimant's employment did contribute in "some way" to his degenerative disc disease.

That employment, however, was more likely than not a material rather than a major contributor. (Ex. 105-9). We note that, at the time of the December 1996 denial, a consulting neurologist, Dr. Edmonds, stated that claimant's 1992 injury was not contributing to his symptoms and that his chronic back pain was due to degenerative disease. (Ex. 74-2). Dr. Daskalos, claimant's then-attending physician, concurred with the Edmond's report. (E. 76). Dr. Daskalos further reported that claimant's problems were related to degenerative disc disease and possibly spinal stenosis and "may be unrelated to the 1992 injury." *Id.*

Based on our *de novo* review of the record, we find that claimant's 1997 degenerative disc disease condition is not related in major part to his overall 15-year employment, including his compensable 1992 low back injury. ORS 656.802(2)(a). Assuming that degenerative condition preexisted claimant's employment, we further find that the medical evidence does not establish that employment conditions were the major contributing cause of the "combined condition" and pathological worsening of the disease. ORS 656.802(2)(b). Thus, we affirm.

ORDER

The ALJ's order dated November 2, 1998 is affirmed.

March 26, 1999 Cite as 51 Van Natta 487 (1999)

In the Matter of the Compensation of
ANNIE L. BOUNDS, Claimant
WCB Case No. 97-10293
ORDER DENYING RECONSIDERATION
G. Joseph Gorciak III, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our March 4, 1999 order that set aside the Orders on Reconsideration and Notice of Closure as premature and remanded the claim to the insurer for further processing according to law. The insurer argues that its denial satisfied the "one express requirement" of OAR 436-030-0034(3), *i.e.*, that the worker be informed that claim closure will result from the denial and, therefore, the claim was not prematurely closed.

After reviewing the insurer's motion, we have nothing further to add to our prior order. For the reasons discussed in our previous decision, we adhere to our conclusion that the insurer's denial did not strictly comply with OAR 436-030-0034(3). Consequently, the insurer's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our March 4, 1999 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL B. KNIGHT, Claimant
WCB Case No. 98-06332
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Moller.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for an umbilical hernia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a laborer in June 1998. On Friday, June 26, 1998, he felt "something pull" in his stomach while reaching to place a pan holding shackles on a scale at work. He had stomach pain thereafter and obtained permission to leave work early.

On Saturday, June 27, 1998, claimant bench pressed weights on a weight bench at his grandmother's house. When he sat up, he felt "exquisite" stomach pain. (*See* Tr. 22; Ex. 3A). Claimant had continuing stomach pain and started bleeding from his navel on Sunday night.

Claimant worked about two hours on Monday, June 29, 1998, then sought medical treatment. Dr. Cleland diagnosed an umbilical hernia and referred claimant to Dr. Cramer.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant credible based on his demeanor and manner of testifying at hearing. Based "almost entirely" on claimant's testimony, the ALJ also found that claimant's hernia had its onset with a reaching incident at work on June 26, 1998. The ALJ opined that claimant's subsequent activities were so limited that they did not contribute to his hernia and that claimant "probably would not have suffered anything in the absence of the injury he sustained at work." The ALJ concluded that claimant's history regarding the work incident was medically consistent with his hernia condition, reasoning that Dr. Cramer's ignorance regarding claimant's subsequent off-work weightlifting activities was "of no consequence." We disagree.

Although we generally defer to an ALJ's demeanor-based credibility finding, we decline to do so in this case because we find material inconsistencies in the record that cast doubt on the accuracy of the medical histories. Under these circumstances, we give the ALJ's credibility finding little weight.[1] Moreover, where a claimant's reporting is inconsistent or incomplete, a medical opinion based on that reporting is unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) ("[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."); *James D. Shirk*, 41 Van Natta 90, 93 (1989) (a physician's opinion based on a patient's history is only as reliable as the history is accurate).

Dr. Cleland examined claimant on June 29, 1998, after the work and off-work incidents. He reported that claimant "had onset a week and a half to two weeks ago of pain and bleeding in naval."[2] (Ex. 2).

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[1] *See Erck v. Brown Oldsmobile*, 311 Or App 519, 528 (1991); *Davies v. Hamel Lumber Co.*, 67 Or App 35 (1984); *see also Gail A. Albro*, 48 Van Natta 41, 42 (1996) (inconsistencies in the record may be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible); *Angelo L. Radich*, 45 Van Natta 45 (1993) (same).

[2] Claimant testified that he did not know where Dr. Cleland got that history. (Tr. 26). Claimant also argues that Dr. Cleland's signature on the "827" form indicates that he understood that claimant's stomach symptoms actually began at work on June 26, 1998. (*See* Ex. 3). Assuming (without deciding) that Dr. Cleland intended to relate claimant's hernia to his work activities, his opinion would not be particularly persuasive because he did not address the timing of claimant's symptoms and there is no indication that he was aware of claimant's off work activities and associated symptoms.

Dr. Cramer examined claimant on July 9, 1998. He recorded claimant's June 26, 1998 work incident and subsequent "exquisite pain" when "sitting up" at home thereafter. (Ex. 3A). Dr. Cramer opined that claimant's hernia occurred with the Friday reaching incident at work, without explanation. There is no indication that claimant told Dr. Cramer that his "exquisite pain" upon "sitting up" was also associated with weight lifting. Under these circumstances, we cannot say that Dr. Cramer's causation opinion is based on an accurate and complete history. Moreover, considering the course of claimant's symptoms (including the off-work worsening) and the incomplete medical histories, we cannot say that the weightlifting activities were "of no consequence" to his hernia. Accordingly, because there is no medical evidence supporting the claim which is also based on an accurate and complete history regarding claimant's activities and symptoms, we uphold SAIF's denial of claimant's injury claim.

ORDER

The ALJ's order dated November 25, 1998 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

March 26, 1999 Cite as 51 Van Natta 489 (1999)

In the Matter of the Compensation of
BOBBY D. DREW, Claimant
Own Motion No. 66-0092M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On March 16, 1999, the SAIF Corporation submitted its request to reopen claimant's claim under our own motion jurisdiction to provide reimbursement for a medical file review to determine the compensability of requested medical services as they relate to his compensable July 19, 1957 injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

We have previous held that diagnostic medical services are compensable when the services are reasonable and necessary in order to establish a causal relationship between the compensable condition and the current condition. *Carl Hight*, 44 Van Natta 224 (1992) and *Cordy A. Brickey*, 44 Van Natta 220 (1992). In keeping with our holdings in *Hight, supra* and *Brickey, supra*, we find that the medical report generated as result of the medical file review an integral part of a medical service provided to an injured worker. As such, we conclude the medical file review report qualifies as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested medical file review is reasonable and necessary and is justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for the costs of a medical file review.

This order shall supplement our August 13, 1992 order that previously reopened claimant's 1957 claim for the payment of medical services which are found to be reasonable and necessary and causally related to the compensable injury.

This authorization for compensable medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANTONIO J. VARGAS, Claimant
WCB Case No. 98-06811
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that awarded a $3,000 assessed attorney fee under ORS 656.386(1) for claimant's counsel's services at hearing. SAIF also moves form remand. On review, the issue is attorney fees.

We deny SAIF's motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of his injury claim. Following the hearing, the ALJ found that claimant had established the compensability of his knee injury, and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $3,000 after considering the factors set forth in OAR 438-015-00010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that his explanation for the $3,000 fee award is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood,* 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood,* 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors he considered in determining the fee. The ALJ explained that, in awarding the $3,000 fee, he particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated. This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale.[1] *See Leslie D. Custer,* 51 Van Natta 390 (1999).

ORDER

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

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[1] Because SAIF challenged only the attorney fee award on review and 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 review. *See Dotson v. Bohemia, Inc.,* 80 Or App 233 (1998).

In the Matter of the Compensation of
MARIETTA Z. SMITH, Claimant
WCB Case Nos. 98-04425, 97-06269 & 96-11437
ORDER ON RECONSIDERATION
Darris K. Rowell, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of those portion of our February 25, 1999 Order on Review that: (1) adopted and affirmed that portion of an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's November 26, 1996 denial of claimant's right knee occupational disease (OD) claim on the ground that "work activity [was] not the major contributing cause of the development of [the] condition diagnosed as degenerative joint disease, bilateral knees"; and (2) affirmed that portion of the ALJ's order that upheld SAIF's April 30, 1998 denial of claimant's OD claim for the same condition on the ground that the condition "has not resulted in any treatment or disability."[1]

On reconsideration, claimant argues that the April 30, 1998 denial should be set aside because the record establishes that her right knee condition did require treatment and/or result in disability. Claimant also challenges the ALJ's statement that the right knee OD was not denied on "causation" grounds, and she asserts that this condition was encompassed in SAIF's November 26, 1996 "causation" denial.

Claimant further contends that our February 25, 1999 order incorrectly adopts and affirms "that portion of the ALJ's order that upheld SAIF's November 26, 1996 denial of claimant's right knee OD claim." Claimant reasons that the ALJ neither upheld nor set aside the November 26, 1996 denial because he incorrectly assumed that it did not encompass the right knee OD. Claimant asks us to address the merits of the November 26, 1996 "causation" denial and conclude that the record establishes the requisite causal link between claimant's work activity and her right knee condition.

In the event we set aside the November 26, 1996 denial of the right knee OD, claimant argues that "the April 30, 1998 denial on new grounds should be considered moot." In the alternative, claimant contends that SAIF's April 30, 1998 denial effectively withdrew and replaced the November 26, 1996 denial of the right knee OD.

We first address claimant's argument that the April 30, 1998 denial should be set aside. Claimant asserts that the ALJ erred in finding that claimant's right knee condition has not required treatment or resulted in disability. In her brief on review, claimant raised this issue, but did not cite any evidence supporting her argument. On reconsideration, claimant relies on Dr. Hall's July 31, 1996 chart note, which reads in pertinent part:

> "[Claimant] comes in, said her *knees* are still uncomfortable, but doing better. She still has a lot of discomfort and is worried about going back to work and what will happen to her *knees*. * * * Will keep her off work for a couple of days and see her back if she does not improve[.]" (Emphasis supplied). [See Ex. 2-4]

We are not persuaded that this chart note establishes that claimant's right knee condition required treatment or resulted in disability within the meaning of ORS 656.005(7)(a). With the exception of the reference to claimant's report of bilateral knee pain, the focus of the chart note is on the left knee condition and related findings. There is no documentation of a right knee diagnosis, or treatment or disability related specifically to that knee. And there is no further documentation of right knee pain until July 1997. [See Exs. 4, 6, 13, 15, 18, 19, 23]. In fact, according to Dr. James' February 6, 1997 examination report, claimant stated that her right knee has not bothered her since she fell in April 1995. [See Ex. 18-6].

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[1] We acknowledge that SAIF has filed a petition for judicial review of our February 25, 1998 order. Nevertheless, 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). Since the 30-day period within which to withdraw and reconsider our order has not expired, we retain authority to alter our prior decision. *SAIF v. Fisher*, 100 Or App 288 (1990).

Furthermore, for the reasons discussed by the ALJ, we are not persuaded that the testimony of claimant and her husband establishes that Dr. Becker prescribed a brace for claimant's right knee. Nor are we persuaded that the record otherwise establishes that claimant's treating doctors provided treatment or authorized time loss for that condition. The only other documentation of a right knee condition is in Dr. James' July 7, 1997 examination report. [See Exs. 25, 27]. Specifically, Dr. James noted complaints of occasional right knee pain and right knee findings of pain on palpation and 1+ valgus instability in flexion bilaterally. And he opined that claimant likely had preexisting "genu varum, bilaterally." But Dr. James did not identify any treatment or disability specifically related to claimants' right knee. Furthermore, Dr. James was an independent medical examiner rather than a treating or consulting physician.

We next address claimant's contention that the ALJ incorrectly found that SAIF did not deny claimant's right knee OD claim on "causation" grounds. We agree. SAIF's November 26, 1996 denial expressly asserts that work activity was not the major contributing cause of claimant's *bilateral* degenerative knee joint disease. On the other hand, we do not agree that the ALJ did not uphold the November 26, 1996 denial of the right knee OD. The "Issue" section of the ALJ's order states that "[i]n WCB Case 96-11437, claimant appealed SAIF's November 26, 1996 denial of [claimant's] claim for *bilateral* knee conditions." (Emphasis supplied). And the ALJ's "Order" section provides that "[i]n WCB Case 96-11437, SAIF's November 26, 1996 denial is set aside to the extent it denied claimant's left knee degenerative condition, and it is upheld *in all other respects*." (Emphasis supplied). We conclude that the effect of this order language was to uphold the November 26, 1996 denial of the right knee OD.

At the same time, we acknowledge that the discussion in the "Conclusion and Opinion" section of the ALJ's order is limited to the April 30, 1998 denial. Consequently, we offer the following supplemental rationale in support of the ALJ's "Order" language upholding the November 26, 1996 denial of claimant's right knee OD.

Claimant argued in her cross-appellant's brief that SAIF's November 26, 1996 denial of a right knee OD should be set aside as premature. In support of that contention, claimant relies on the ALJ's finding that her right knee condition did not require treatment or result in disability. Claimant further notes that her letter expressly requesting compensation for the right knee was not sent until January 30, 1998. We are not persuaded by claimant's argument. The "parts affected" portion of claimant's September 4, 1996 Form 801 lists both the right and the left knee. Consequently, the Form 801 was an initial OD "claim" for the right knee condition as that term is defined in ORS 656.005(6). The fact that claimant may not have required treatment or incurred disability is relevant in determining the compensability of this claim under ORS 656.005(7)(a). But it does not negate SAIF's duty to respond to the September 4, 1996 Form 801.

We next address claimant's argument that SAIF's April 30, 1998 denial withdrew and replaced the November 26, 1996 denial of the right knee OD. Based on this assumption, claimant reasons that SAIF conceded the causation issue when it issued the April 30, 1998 denial. Thus, claimant contends that the ALJ should not have upheld the November 26, 1998 denial insofar as it denied the right knee OD.

Claimant did not raise this procedural challenge in her brief on review. Nor is there evidence in this record that claimant made this procedural argument at hearing. Under these circumstances, we are not inclined to address this issue on reconsideration. *Accord 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). Furthermore, a determination that the November 26, 1996 denial was withdrawn would not result in a compensable right knee OD in light of our conclusion above that this condition has not resulted in treatment or disability.

Moreover, if we were to address claimant's procedural challenge, we would not be persuaded that SAIF's April 30, 1998 denial effectively withdrew and replaced the November 26, 1996 denial of claimant's right knee OD claim. Claimant cites no statute or case law supporting such a finding, and we find none. Furthermore, the April 30, 1998 denial does not expressly or impliedly provide for the withdrawal or replacement of the November 26, 1996 denial. Consequently, we conclude that the latter denial remained in effect, and that the April 30, 1998 denial merely provided an additional basis for SAIF's claims processing action.

Finally, we address claimant's contention that we should set aside SAIF's November 26, 1996 "causation" denial because the record establishes the requisite causal relationship between claimant's work and her right knee condition. Claimant did not make this argument in her cross-appellant's brief on review. Rather, as discussed above, claimant only challenged the procedural propriety of the denial. We are not inclined to address the substantive merits of SAIF's causation denial when that issue was raised for the first time on reconsideration. *Accord Christine M. Mulder*, 50 Van Natta at 518. Moreover, we have concluded above that claimant's right knee condition did not require treatment or result in disability within the meaning of ORS 656.005(7)(a). For this reason, the right knee OD claim would not be compensable even if the requisite causal relationship was established.

In summary, we adhere to our initial decision affirming that portion of the ALJ's order that upheld SAIF's April 30, 1998 denial of claimant's right knee OD claim on the ground that the condition did not require treatment or result in disability. We also adhere to our initial decision affirming that portion of the ALJ's order that upheld SAIF's November 26, 1996 denial of claimant's right knee OD claim on "causation" grounds.

Accordingly, we withdraw our February 25, 1999 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our February 25, 1999 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
JERRY L. BROWN, Claimant
WCB Case No. 98-05265
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that assessed a $3,000 attorney fee for claimant's counsel's services at hearing. SAIF also moves for remand. In his brief, claimant requests sanctions under ORS 656.390 based on SAIF's allegedly frivolous request for review. On review, the issues are remand, attorney fees, and sanctions.

We deny SAIF's motion for remand and claimant's motion for sanctions, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of his aggravation claim. Following the hearing, the ALJ found that claimant had proven his claim and directed SAIF to accept and process it. The ALJ also assessed an attorney fee of $3,000 after considering the factors set forth in OAR 438-015-0010(4) and applying them to the case.

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that his explanation for the $3,600 fee award is insufficient. Contrary to SAIF's contention, the ALJ was not required to make findings for each rule-based factor. As we explained *Daryl L. Underwood*, 50 Van Natta 2330 (1998), where there is no specific argument at hearing concerning the application of the factors in OAR 438-015-0010(4), an ALJ satisfies his or her obligation to make findings concerning the attorney fee award by including in the order a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. Furthermore, because we are authorized to modify or supplement the ALJ's order on review under ORS 656.295(6), remand is not an appropriate remedy. *Daryl L. Underwood*, 50 Van Natta at 2332.

Here, the ALJ cited to the applicable rule and identified the factors he considered in determining the fee. The ALJ explained that, in awarding the $3,600 fee, he particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated. This explanation for the ALJ's attorney fee award is consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999).

We turn to claimant's request for sanctions against SAIF for a frivolous request for review. "Frivolous" means the matter is not supported by substantial evidence or is initiated without reasonable prospect of prevailing. ORS 656.390(2).

SAIF has presented a colorable argument on review that is sufficiently developed so as to create a reasonable prospect of prevailing on the merits. While the argument on review did not ultimately prevail, we cannot say it is "frivolous." *Jack B. Hooper*, 49 Van Natta 669 (1997); *Donald M. Criss*, 48 Van Natta 1569 (1996). Accordingly, we deny claimant's request for sanctions.

Finally, because SAIF challenged only the attorney fee award on review and 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 review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1998).

ORDER

The ALJ's order dated October 23, 1998 is affirmed.

March 29, 1999 Cite as 51 Van Natta 494 (1999)

In the Matter of the Compensation of
JONATHAN D. HOEYE, Claimant
Own Motion No. 98-0365M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable fracture, left femur; two lacerations, volar aspect right wrist injury. Claimant's aggravation rights expired on December 16, 1987. SAIF issued a denial of the compensability of claimant's current deep vein thrombus, left thigh condition on August 31, 1998. Claimant timely appealed that denial. (WCB Case No. 98-08528). In addition, SAIF opposed authorization of temporary disability compensation, contending that: (1) it is not responsible for claimant's current condition; and (2) 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.

Here, claimant did appeal the August 31, 1998 denial; however, he failed to appear at the scheduled hearing. The Administrative Law Judge found that there were no extraordinary circumstances for his failure to appear and issued an Order of Dismissal issued on February 1, 1999. That order has not been appealed. Thus, the current deep vein thrombus, left thigh condition for which claimant requests own motion relief remains 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
DONALD D. PAUL, Claimant
WCB Case No. C9-00057
SECOND ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Coughlin, et al, Claimant Attorneys
Barbara A. Woodford, Defense Attorney

Reviewed by Board Member Bock and Haynes.

On March 11, 1999, we denied claimant's request for reconsideration of our January 25, 1999 approval of the parties' claim disposition agreement (CDA). On March 22, 1999, the Board received another letter from claimant concerning the approved CDA. We treat the letter as a second motion for reconsideration.

As noted in our prior order denying reconsideration, 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). Because claimant's motion for reconsideration of the approved CDA was filed more than 10 days after our January 25, 1999 approval, the motion is untimely. Therefore, 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, as previously explained the CDA was approved in a final order pursuant to ORS 656.236; it is final and is not subject to review. ORS 656.236(2).

Claimant refers to the appeal rights on the Administrative Law Judge's (ALJ's) January 26, 1999 order and argues that he has 30 days to appeal the CDA. Although claimant had 30 days to appeal the ALJ's dismissal[1] order under ORS 656.289(3), a CDA is different. As explained in our previous order, no appeal may be taken from a final order approving a CDA. ORS 656.236(2). In addition, after the expiration of the Board's 10-day reconsideration period, the Board has no authority to reconsider the CDA. *See* OAR 438-009-0035(1),(2). Consequently, we deny claimant's motion for reconsideration.[2]

IT IS SO ORDERED.

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[1] Claimant's request for Board review of the ALJ's dismissal order has been acknowledged. A briefing schedule has been implemented, which will permit claimant to present his written arguments explaining why he believes the ALJ improperly dismissed his hearing request in response to our approval of the parties' CDA.

[2] Claimant raises issues related to the approved CDA such as payment of CDA proceeds and benefits, including surgery/medical treatment and travel expenses. Those issues are within the Director's jurisdiction, rather than the Board's authority. Should claimant have further questions regarding these issues, he may wish to contact the Ombudsman's office at 1-800-927-1271.

In the Matter of the Compensation of
CONNI K. HEIFORT, Claimant
WCB Case No. 98-06186
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that: (1) admitted Exhibits 3 through 17 and 19 through 27 in evidence; and (2) reduced her unscheduled permanent disability for a cervical and low back condition from 41 percent (131.2 degrees), as awarded by an Order on Reconsideration, to zero. On review, the issues are evidence and extent of unscheduled permanent disability.

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

Evidence

Claimant argues that the ALJ erred by admitting Exhibits 3 through 17 and 19 through 27 in evidence. According to claimant, those exhibits are not from "approved sources," *i.e.*, from the medical arbiter or attending physician and, therefore, they should not be admitted in evidence.

The insurer contends that medical records generated before claim closure are admissible in extent of permanent disability cases as long as they were submitted at reconsideration. *See* ORS 656.283(7) ("[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing"). The exhibits at issue in this case were submitted at reconsideration. We agree with the ALJ's conclusion that, although only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's findings may be considered in rating impairment, that does not otherwise make the exhibits cited by claimant inadmissible.

In any event, even if we assume, without deciding, that the record should be confined to the evidence cited by claimant, *i.e.*, Exhibits 1, 2, 18, and Exhibits 28 through 39, we would reach the same conclusion.

For the purpose of rating permanent disability, only the opinions of claimant's attending physician at the time of claim closure, or any findings with which he or she concurred, and the medical arbiter's findings, if any, may be considered. *See* ORS 656.245(2)(b)(B), ORS 656.268(7); *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994). Under OAR 436-035-0007(13) (WCD Admin. Order No. 96-072), where a medical arbiter is used on reconsideration, "impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." The "preponderance of medical evidence" standard prescribed by the disability standards to determine a worker's level of impairment is limited to the above three medical sources. *Adam J. Delfel*, 50 Van Natta 1041, 1043 (1998).

Claimant was compensably injured on June 4, 1997 and the insurer accepted a cervical spine strain and left sacroiliac strain. (Ex. 18). Dr. Ward was claimant's attending physician at the time of closure. Dr. Ward concurred with Dr. Jones' April 6, 1998 report. (Ex. 33). Dr. Jones reported that claimant had no objective findings to support her subjective complaints. (Ex. 32-4). He explained:

> "The patient shows clear and obvious functional overlay with dramatic pain behavior, both during the history and the physical examination, withdrawal to light skin palpation on the skin of the back, mismatch between seated and supine straight leg raising tests, give-way in the anterior tibialis and extensor hallucis longus in the left foot, nonanatomic distribution of sensory change, and rather dramatic pain behavior with straight leg raising in a supine position." (*Id.*)

Dr. Jones concluded that functional overlay was the "chief driving need" for claimant's continued need for treatment. (*Id.*) He felt claimant was medically stationary and should return to full duty work. (*Id.*)

Dr. Jones believed that it was "completely unlikely" that claimant would still have symptoms from the type of accident she had in June 1997, in light of the negative studies. (Ex. 32-5). He concluded that claimant had no impairment. (*Id.*) Dr. Ward, claimant's attending physician, concurred with Dr. Jones' report. (Ex. 33).

Dr. Berselli performed a medical arbiter examination on July 7, 1998. (Ex. 38). He reported that claimant had a limited ability to repetitively use her neck and low back. (Ex. 38-2). Although Dr. Berselli's findings indicated that claimant's lumbar flexion test was invalid (Ex. 38-3), he did not discuss that finding in the body of his report. Furthermore, although Dr. Berselli reported that findings in claimant's hands and left foot did not follow a dermatomal pattern (Ex. 38-1), he did not discuss or explain whether or not that had an impact on claimant's impairment. Because Dr. Berselli's report is conclusory and lacks adequate explanation, it is not persuasive.

Instead, we conclude that Dr. Jones' report, with which Dr. Ward concurred, provided the most thorough, complete and well-reasoned evaluation of claimant's impairment. We agree with the ALJ that claimant is not entitled to an award of unscheduled permanent disability.

ORDER

The ALJ's order dated December 15, 1998 is affirmed.

In the Matter of the Compensation of
TOMMY L. BROWN, Claimant
WCB Case No. 98-03270
ORDER DENYING MOTION TO DISMISS
Michael A. Bliven, Claimant Attorney
Reinisch, et al, Defense Attorneys

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's claim for an abdominal injury. Contending that a copy of the request was not timely served on all parties, claimant has moved the Board for an order dismissing the insurer's request for review. After considering the insurer's response and claimant's reply, we deny the motion.

FINDINGS OF FACT

Claimant requested a hearing regarding the insurer's denial of his abdominal condition. Pursuant to the ALJ's February 3, 1999 order, the insurer's denial was set aside and the claimant's attorney was awarded an attorney fee. Copies of the ALJ's order were mailed to claimant, his attorney, the employer, its insurer and their attorney.

By a letter dated February 4, 1999, claimant's attorney advised the Hearings Division that claimant's address had changed. A copy of the letter was mailed to the insurer and its attorney. On March 1, 1999, the insurer's attorney mailed a request for review of the ALJ's order to the Board by certified mail. The request certified that a copy of the request had been served on claimant and his attorney. The request, however, was mailed to claimant's former address.

An acknowledgment of the insurer's request for review was mailed by the Board on March 3, 1999. The acknowledgment was mailed to claimant, claimant's attorney, the insurer, employer and their attorney. The acknowledgment was also addressed to claimant's former address.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice received within the statutory period. *Argonaut Insurance v. King*, 63 Or App 847, 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). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." *Robert Casperson*, 38 Van Natta 420, 421 (1986). Yet, in the absence of prejudice to a party, timely service of a request for review on the attorney for a party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. *Argonaut Insurance v. King*, 63 Or App at 850-51; *Nollen v. SAIF*, 23 Or App 420, 423 (1975).

Here, the 30th day after the ALJ's February 3, 1999 order was March 5, 1999. Therefore, the final day to perfect a timely appeal of the ALJ's order was March 5, 1999.

Based on the insurer's counsel's unrebutted March 1, 1999 Certificate of Mailing, we are persuaded that claimant's attorney was notified of the request for Board review prior to the expiration of the aforementioned 30-day period. *Harold E. Smith*, 47 Van Natta 703 (1995). Inasmuch as no contention has been made that claimant has been prejudiced by not directly receiving a copy of the insurer's request for review, we hold that the insurer's timely service by mail upon claimant's counsel is adequate compliance with ORS 656.295(2).[1] *See King*, 63 Or App at 847; *Nollen*, 23 Or App at 420; *Nancy C. Prevatt-Williams*, 48 Van Natta 242 (1996).[2]

In conclusion, we are persuaded that the insurer's counsel's mailing of a copy of the request for review to claimant's counsel provided sufficient compliance with ORS 656.292(2) to vest appellate jurisdiction with the Board. Accordingly, claimant's motion to dismiss is denied. In light of these circumstances, the briefing schedule will be revised as follows. The insurer's appellant's brief shall be due 21 days from the date of this order. Claimant's respondent's brief shall be due 21 days form the date of mailing of the insurer's brief. The insurer's reply brief shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Although claimant asserts that the insurer's appeal of the ALJ's order has "seriously prejudiced" him in that it has resulted in financial hardship because his benefits have been stayed pending the appeal, he does not indicate that his failure to receive a copy of the insurer's request for review prejudiced his ability to respond to the insurer's appeal or his ability to present his case on review. In any case, we note that claimant does not identify any benefits that would not have been stayed had the request been properly served on both claimant and his attorney. Furthermore, if there were benefits that were due pending appeal, claimant's attorney could seek payment of those benefits. Under such circumstances, we are not persuaded that claimant has been prejudiced by the insurer's failure to provide him with his own copy of the request for review.

[2] We acknowledge claimant's citation to *Charlotte M. Soros*, 50 Van Natta 2072, *on recon*, 50 Van Natta 2233 (1998). In that case, a lack of service of the request on the claimant's attorney (as required by the Board's rule) did not prevent jurisdiction from vesting in the Board where the claimant had been timely notified of the appeal. Here, claimant was not served with the request for review (as required by rule and statute). Board and court precedent, nevertheless holds that service on an attorney, in the absence of prejudice, is sufficient compliance with the statute to vest appellate jurisdiction with the Board.

In the Matter of the Compensation of
ROBERT L. FOWLER, Claimant
Own Motion No. 98-0300M
OWN MOTION ORDER
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable cervical/thoracic strain with bilateral thoracic outlet syndrome. Claimant's aggravation rights expired on September 4, 1984. SAIF opposed reopening the claim on the grounds that claimant's request for neurolysis of left brachial plexus for thoracic outlet syndrome is not reasonable and necessary treatment for his compensable condition.

SAIF requested Director's review of the requested medical treatment, as jurisdiction over medical service disputes resides with the director. ORS 656.245(6), 656.260, 656.327 and 656.704(3). On August 17, 1998, the Board issued its order postponing action on the own motion matters pending outcome of the medical services dispute.

On February 10, 1999, the Medical Review Unit (MRU) issued an Administrative Order (Order No. TX 99-119), which found that the recommended neurolysis of left brachial plexus for thoracic outlet syndrome was appropriate medical treatment for claimant's compensable injury. That order became final on March 12, 1999.

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

Here, the dispute regarding the reasonableness and necessity of claimant's surgery has been resolved. ORS 656.327. Because it has been determined that SAIF is responsible for claimant's proposed medical treatment, we find that claimant is entitled to temporary disability compensation for surgery which has been determined to be reasonable and necessary for claimant's compensable condition.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT KRUSE, Claimant
WCB Case No. 98-02974
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that : (1) upheld the insurer's denial of claimant's injury claim for his current left shoulder condition; and (2) declined to assess a penalty or related attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

Compensability

On review, claimant contends that the opinion of her treating physician, Dr. Thomas, establishes the compensability of claimant's current left shoulder condition. The ALJ concluded that Dr. Thomas' opinion was not persuasive because he was not aware of claimant's August 1997 skiing injury to her left shoulder. We agree with the ALJ's conclusion and rationale on this issue. But we note that the ALJ's order does not discuss the substance of Dr. Thomas' opinion. Accordingly, in the interest of clarity, we offer the following summary of that opinion.

On March 17, 1998, Dr. Thomas opined that claimant's current left shoulder condition was a continuation of his 1994 problem, based on claimant's history of left shoulder problems dating back to the compensable 1994 injury. In a subsequent opinion on March 23, 1998, Dr. Thomas stated that "the expired time since the [1994] injury does cause a reasonable doubt as to the major contributing cause [of claimant's current left shoulder condition] as he has been working in construction." Finally, in a July 2, 1998 concurrence, Dr. Thomas indicated that the 1994 injury was the major contributing cause of claimant's current left shoulder condition and related treatment and disability.

Penalties and Related Fees

In light of our conclusion on the compensability issue, there are no amounts then due on which to assess a penalty, and there has been no unreasonable resistance to the payment of compensation giving rise to an attorney fee. ORS 656.262(11)(a) and 656.382(1). For this reason, we affirm the ALJ's ultimate decision that claimant is not entitled to penalties and/or attorney fees for the insurer's allegedly unreasonable denial.

ORDER

The ALJ's order dated November 20, 1998 is affirmed.

In the Matter of the Compensation of
LARRY A. MORGAN, Claimant
WCB Case No. 96-03555
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Moller and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of his occupational disease claim for a cervical disc condition. On review, the issue is compensability.

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

Claimant, age 54 at the time of hearing, has worked for the employer, a paper mill, since September 1970. For the first few months of his employment, he worked on the yard crew, unloading rail cars. After yard crew, claimant spent approximately 18 months working as a "chipper," where his job duties involved using a crow bar to pry wood chips out of the rail cars. Like the yard crew, chipping was strenuous work. As a chipper, claimant experienced aching in his neck, arms and legs until his body became conditioned to the activity.

In early 1973, claimant began working on the paper machine. This work was also physical, although not as intensive as chipping. In approximately 1974, claimant started working in the technical line of progression, as a relief paper tester and pulp tester. During this time (1974 or 1975), claimant also periodically filled in as a chipper. When he did the chipper work, he again experienced aching in his shoulders, neck and arms.

In approximately September 1975, claimant was hospitalized for an ulcer condition. He missed a few months of work. He also experienced headaches and a low back injury during the mid-1970s.

In approximately 1977, claimant bid into a position in the lab, which was lighter duty work. His headaches and body aches subsided. Claimant continued in various positions in the lab and was essentially symptom-free until the early 1990s, when he experienced a recurrence of neck, shoulder and arm pain while working as a sampler. He sought treatment in April 1992, and was ultimately diagnosed with bilateral carpal tunnel syndrome.

In September 1993, claimant began treating with Dr. Long, who diagnosed bilateral carpal tunnel syndrome, ulnar compression neuropathy at the elbows, and myofascial pain involving the arms and shoulders. Dr. Long found no evidence of cervical radiculopathy. Claimant filed an occupational disease claim for these conditions, which the employer was ordered to accept in a January 1995 Opinion and Order.

In November 1995, claimant returned to Dr. Long complaining, among other things, of continuing neck stiffness. A November 11, 1995 cervical MRI showed mild cervical spondylosis at C4-5 and C5-6 with mild bilateral C5 root irritation. In January 1996, claimant was referred to Dr. Berkeley, who recommended surgery. Dr. Long subsequently opined that claimant's cervical condition was caused by his work activities for the employer, particularly his chipper duties in the early 1970s.

In February 1996, claimant was examined by Dr. Kirshner, a neurologist, at the employer's request. Dr. Kirshner found no nervous system dysfunction and recommended against surgery. Dr. Kirshner opined that claimant's mild cervical spondylosis was due to aging and the degenerative process and not his work activities for the employer.

The employer denied the compensability of claimant's cervical disc degeneration, and claimant requested a hearing. The ALJ determined that Dr. Long's opinion was unpersuasive and insufficient to sustain claimant's burden of proof on compensability.

On review, claimant maintains that Dr. Long's opinion (and the concurrence of Dr. Berkeley) persuasively establishes that his work activity for the employer is the major contributing cause of his cervical disc degeneration and spondylosis. Like the ALJ, we find to the contrary.

Dr. Long has opined that claimant's work activity, particularly his heavy work as a chipper in the early 1970s, constituted repetitive cervical trauma that accelerated the degeneration of claimant's cervical spine. Dr. Long's opinion was based on claimant's history of persistent neck pain and headaches in the early and mid-1970s as well as his understanding that claimant missed about six months of work during this time due to these symptoms.[1] (*See, e.g.* Exs. 50A, 60, 61 pp. 12-14). In his deposition, however, Dr. Long acknowledged that if claimant's symptoms had not been persistent and/or if claimant had not missed months work due to these symptoms, this information would affect his opinion.

Although we are persuaded that claimant experienced body aches when he started work as a chipper in the early 1970s and also when he periodically returned to chipping duties in the mid-1970s, we are not persuaded that he missed six months of work because of persistent headaches and neck pain during either time period. Rather, we find that, to the extent claimant was out of work for a few months in the mid-1970s (while he was working on the technical line of progression), his time loss was due to an ulcer condition and/or a lower back injury, rather than headaches and neck pain.[2] Consequently, we agree with the ALJ that Dr. Long's opinion is based on an inaccurate history. Because it is based on a faulty history, Dr. Long's opinion is not persuasive. *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).

In the absence of a persuasive medical opinion linking claimant's cervical disc degeneration and spondylosis to his work activity for the employer, claimant cannot sustain his burden of proof under ORS 656.802(2).

ORDER

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

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[1] Dr. Long also relied on a study related to degenerative change in the cervical spine due to load-carrying on the head. But in his deposition, Dr. Long admitted that the study was not directly relevant, because claimant's work activity did not involve direct loading on the spine. (Ex. 61).

[2] At hearing, claimant could not recall how much time, if any, he missed from work because of headaches and neck pain. Although he initially did not recall missing time from work for any other reason, he later admitted he was off work for some time due to a low back injury and also that he missed at least three months of work because of an ulcer condition. (Tr. 79). Dr. Goby's chart notes also document that claimant was off work for three months beginning in October 1975 because of his ulcer and frustration with rotational shifts. (*See* Ex. A.). Although claimant did report persistent headaches during December 1975 and January 1996, he had essentially been released from work (because of his ulcer condition) during this time. *Id.*

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Cite as 328 Or 154 (1998) December 17, 1998

IN THE SUPREME COURT OF THE STATE OF OREGON

DONNA ARMSTRONG, Petitioner on Review,
v.
ROGUE FEDERAL CREDIT UNION, Respondent on Review.
(CC 94-2777-L-2; CA A89715; SC S43980)

On review from the Court of Appeals.*

Argued and submitted September 10, 1997.

Thomas C. Howser, of Howser & Munsell, P.C., Ashland, argued the cause for petitioner on review. With him on the brief was Judith H. Uherbelau.

Kevin L. Mannix, of Mannix, Nielsen & Crawford, P.C., Salem, argued the cause and filed the brief for respondent on review.

Geoffrey G. Wren, of Terry & Wren, Portland, filed a brief on behalf of amicus curiae Oregon Trial Lawyers' Association and Oregon Workers' Compensation Attorneys.

D. Michael Dale, of Oregon Legal Services Corporation, Portland, and Maria Andrade, of Oregon Legal Services Corporation, Pendleton, and Monica A. Smith, of Smith Gamson Diamond & Olney, Portland, filed a brief on behalf of amicus curiae Maria Villegas and Oregon AFL-CIO.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Durham, and Kulongoski, Justices.**

VAN HOOMISSEN, J.

The decision of the Court of Appeals and the judgment of the circuit court are reversed, and the case is remanded to the circuit court for further proceedings.

*Appeal from Jackson County Circuit Court, Mitchell A. Karaman, Judge. 145 Or App 268, 929 P2d 1066 (1996).

**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.

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328 Or 157> The issue in this case is whether an employer (defendant) commits an unlawful employment practice under ORS 659.415 by denying an injured worker's (plaintiff's) demand for reinstatement during the pendency of litigation over whether the worker's injury is compensable. The Court of Appeals held that a determination that a worker has sustained a compensable injury is a condition precedent to the worker's right to reinstatement under ORS 659.415. *Armstrong v. Rogue Federal Credit Union*, 145 Or App 268, 929 P2d 1066 (1996). For the reasons that follow, we reverse the decision of the Court of Appeals.

ORS 659.415 provides in part:

> "(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position. * * *
>
> "* * * * *
>
> "(4) Any violation of this section is an unlawful employment practice."

The parties stipulated to the material facts. On May 25, 1990, plaintiff's physician ordered her off work due to stress and depression. Thereafter, she filed a claim for workers' compensation benefits. The insurer, SAIF Corporation (SAIF), on behalf of defendant, Rogue Federal Credit Union, denied plaintiff's claim. Plaintiff challenged the denial and an administrative law judge (ALJ) held a hearing on the matter.

Two years later, on May 22, 1992, before the ALJ had issued a decision, plaintiff's physician released her to return to work. Plaintiff informed defendant of the release and demanded reinstatement to her former position. Defendant refused to reinstate plaintiff and terminated her employment. In September 1992, the ALJ issued an order upholding SAIF's denial on the ground that plaintiff's claim was not compensable.

328 Or 158> On September 27, 1993, the Workers' Compensation Board (Board) ruled that plaintiff's stress and depression was compensable as an occupational disease. Defendant did not seek judicial review of the Board's decision. Thereafter, SAIF paid plaintiff time loss benefits for the period from 1990 to 1994. In 1994, plaintiff filed this action, alleging, *inter alia*, that defendant had committed an unlawful employment practice in 1992 by failing to reinstate her to her former position upon her demand, in violation of ORS 659.415(1).

Before trial, on stipulated facts, the circuit court granted partial summary judgment for defendant. The court reasoned that plaintiff's demand for reinstatement was premature and could not, as a matter of law, give rise to a claim under ORS 659.415. That was so because at the time plaintiff made her demand for reinstatement, her work-related injury or disease had not been determined to be compensable. The court then entered judgment for defendant under ORCP 67 B, dismissing plaintiff's unlawful employment practice claim.

A divided Court of Appeals affirmed. The court's majority considered the text of ORS 659.415(1) in context with Bureau of Labor and Industries regulations. The court held that a worker does not have a right to reinstatement under ORS 659.415(1) unless the workers' compensation claim is in compensable status when the demand for reinstatement is made. Accordingly, the court held that defendant's conduct was not wrongful when it failed to reinstate plaintiff.

The dissent found from the text of ORS 659.415(1) and the context of ORS 656.005(7)(a) that "plaintiff's claim does not depend on whether her employer had accepted her workers' compensation claim before she sought reinstatement." (Armstrong, J., dissenting). The dissent imported the definition of "compensable injury" from ORS 656.005(7)(a) into ORS 659.415(1) and concluded that "a compensable injury, by definition, involves only the worker's condition and not the status of the worker's claim for that injury." *Armstrong*, 145 Or App at 275.

On review, plaintiff argues that ORS 659.415(1) requires an employer to reinstate a worker while the claim proceeds through the administrative process. Additionally, **328 Or 159>** *amicus* argues that the Court of Appeals decision will deny workers the right to be rehired "for the entire time they await a final determination of their claim." *Amicus* further asserts that the Court of Appeals' majority decision "may encourage employers to manipulate the workers' compensation system" by purposely delaying acceptance of a claim.

Defendant contends that ORS 659.415(1) grants reinstatement rights only to a worker whose injury has been determined to be compensable at the time that the worker demands reinstatement. Defendant argues that to extend reinstatement rights to a worker before the injury is deemed compensable would have the effect of eliminating the word "compensable" from ORS 656.415(1). Defendant raises the "prospect of workers being able to assure themselves of reinstatement rights simply by filing bogus claims."

In interpreting a statute, this court's task is to discern the intent of the legislature. *PGE v. Bureau of Labor and Industries*, 317 Or 616, 610-11, 860 P2d 241 (1993); ORS 174.020. To do that, the court first examines the text and context of the statute. If the legislature's intent is clear from text and context, further inquiry is unnecessary. *Id.* at 611.

ORS 659.415(1) provides in part:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement * * *."

"Compensable injury" is not defined in ORS 659.415. The question is: For the purposes of ORS 659.415(1), *when* is an injury a "compensable injury?" We proceed to consider the context of ORS 659.415(1).

The Workers' Compensation Law, ORS chapter 656, is part of the context of ORS 659.415(1). As used in ORS 659.415(1), the term "compensable injury" has the same meaning that it has in the

Workers' Compensation Law, ORS 656.005(7)(a).[1] Generally, a "compensable injury" is an accidental injury that "arises out of and in the course of employment." When a worker is injured at work, the injury is a compensable injury under ORS 656.005(7)(a) from the moment of <328 Or 160> its occurrence, even if the insurer denies that the injury is compensable, and even if the administrative and judicial systems take months or years to determine the validity of the employer's denial. Nothing in the statutory definition of "compensable injury" in ORS 656.005(7)(a) indicates that the definition refers only to an injury that the Board and the courts, after exhaustion of all legal proceedings, have determined to be work-related.

The legislature knows how to condition an employer's liability on an earlier determination that a worker's injury is compensable. For example, an employer is liable for a penalty under ORS 656.735 if a worker suffers a compensable injury when the employer is in a "noncomplying" status (*i.e.*, has failed to purchase or provide coverage for workplace injuries). However, that liability arises only after final closure of the injury claim. ORS 656.054(2) provides:

> "Whenever a subject worker suffers a compensable injury while in the employ of a noncomplying employer, the director shall, *after an order closing the claim has become final,* serve upon the employer a notice of proposed penalty to be assessed pursuant to ORS 656.735(3)." (Emphasis added.)

ORS 659.415 contains no similar language that makes an employer's exposure to a discrimination claim subject to any prior legal determination that the worker's injury is compensable. That distinctive treatment of an employer's liability is significant and tends to defeat defendant's argument here.

For other examples of statutes that expressly condition an employer's liability for a worker's right or benefit on a prior determination of compensability, see ORS 656.262(2) (workers' compensation is payable "except where the right to compensation is denied by the insurer or self-insured employer"); ORS 656.313(1) (employer can suspend duty to pay compensation by requesting hearing, requesting Board review, appealing to a court, or requesting review of certain orders by the Director); ORS 656.313(4)(b) (health insurance providers that pay for services on denied claims are entitled <328 Or 160/161> to reimbursement from employer's insurer "[i]f the services are determined to be compensable").

ORS 659.415(3)(a) provides that the right to reinstatement "terminates" on the occurrence of any one of a list of events. "Terminate" means "to bring to an ending or cessation in time, sequence, or continuity" and "to form the ending or conclusion of." *Webster's Third New Int'l Dictionary,* 2359 (unabridged ed 1993). In logic, a right to reinstatement can come to an end (*i.e.*, terminate) only if it legally exists, has accrued, or is valid before the point of termination. That suggests that the employee may enforce a right to reinstatement, as here, by demanding employment at any time before the occurrence of one of the statutory conditions that "terminates" the right to reinstatement. We note also that the right to reinstatement terminates three years "from the date of the *injury.*" ORS 659.415(3)(a)(F) (emphasis added). The term "injury" necessarily refers to the occurrence of the injury, not the date of a final resolution of all disputes over whether the injury is "compensable."

When a worker is injured at work, and leaves work due to injury, the worker acquires certain statutory rights. First, the worker *may* claim benefits under ORS chapter 656. In the benefits context, the insurer may dispute the compensability of the injury. If the insurer denies the employee's right to compensation, the statutes *expressly* relieve the insurer of the duty to pay most workers' compensation benefits. ORS 656.262(2). If the injury is determined to be compensable in the hearing and appeal process, the insurer is liable for all back benefits, interest, penalties, and attorney fees. ORS 656.313(1)(b); ORS 656.382; ORS 656.385; ORS 656.386. By contrast, ORS 659.415(1) does not relieve an insurer of the duty to reinstate the worker on demand if the employer denies the claim.

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[1] ORS 656.005(7)(a) defines a "compensable injury" in pertinent part as:

> "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means[.]"

A worker who has sustained a compensable injury has a right to reinstatement to the job, if demand is made within three years of injury, if the position exists, is available, and if the worker is not disabled from performing the duties of the position. ORS 659.415(1). Those conditions are met here. The right to reinstatement accrues on the worker's demand for reinstatement; however, a right to reinstatement **<328 Or 161/162>** is not something that an employer must honor in the absence of a demand. Those rights and duties are distinct, even though they each rely on certain identical concepts, such as "compensable injury."

To illustrate, an injured worker *may* lose the right to workers' compensation benefits for a compensable injury by failing to file the 90-day written notice of accident required by ORS 656.265(1) without lawful excuse. Notwithstanding the loss of the rights to obtain benefits, that same worker still may assert the right to reinstatement on demand under ORS 659.415(1) and must prove that the injury was a compensable injury *in the unlawful employment practice proceeding*. In fact, an injured worker need not make a claim for any workers' compensation benefits under ORS chapter 656 in order to be entitled to seek relief from an unlawful employment practice under ORS 659.415. We conclude that an unresolved denial of a worker's claim for workers' compensation benefits is irrelevant to the worker's right to seek relief for a violation of ORS 659.415(1).

Defendant's interpretation of ORS 659.415(1) would impose an immense procedural hurdle and lengthy procedural delay in an unlawful employment practice case, without any support in the text or context of ORS 659.415. That reading could force injured workers to remain off their jobs for months or years after they have regained their health and want to return to work until the merit of an insurer's denial finally is determined. Such a reading would contradict the policies that underlie both ORS 659.415 and the workers' compensation law.

ORS 659.415 is an integral part of the legislative scheme to prohibit employment discrimination on the basis of physical or mental handicap. *Williams v. Waterway Terminals Co.*, 298 Or 506, 510, 693 P2d 1290 (1985), citing *Vaughn v. Pacific Northwest Bell Telephone*, 289 Or 73, 611 P2d 218 (1980). This court has stated that

> "[t]he main purpose of ORS 659.415 is to guarantee that an employer shall not discriminate against a disabled worker for exercising the worker's rights under the Workers' Compensation Law. This statute is but one of a set of statutes reflecting the legislature's concern to prohibit employment **<328 Or 162/163>** discrimination on the basis of handicap." *Shaw v. Doyle Milling Co.*, 297 Or 251, 255, 683 P2d 82 (1984).

ORS 656.012(2)(c) provides that one objective of the Workers' Compensation Law is

> "[t]o restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable[.]"

Our review of the statutory text of ORS 659.415(1), as well as the pertinent context, satisfies us that the legislature's intent is clear and that plaintiff's statutory construction is correct. We understand the concern of an employer that believes, in good faith, but erroneously, that the worker's injury is not compensable. However, if an insurer chooses, for whatever reason, to deny compensability, and the employer is shown to have engaged in an unlawful employment practice under ORS 659.415(1), the worker is entitled to the statutory remedy. We see no justification in the text or context of ORS 659.415 to suspend the discrimination remedy merely because the insurer has decided, in the workers' compensation context, to assert that the injury is not compensable.

The decision of the Court of Appeals and the judgment of the circuit court are reversed, and the case is remanded to the circuit court for further proceedings.

Cite as 157 Or App 619 (1998) December 16, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charlene A. Dieringer, Claimant.

THE NEW PORTLAND MEADOWS and TIG INSURANCE, Petitioners,
v.
CHARLENE A. DIERINGER, Respondent.
(WCB No. 94-13529; CA A91625)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed April 22, 1998. Opinion filed April 15, 1998. 153 Or App 383, 957 P2d 190.

Richard D. Barber and Sheridan & Bronstein, for petition.

No appearance *contra*.

Before Deits, Chief Judge, and De Muniz and Haselton, Judges.

DEITS, C. J.

Petition for reconsideration allowed; opinion modified and adhered to as modified.

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157 Or App 621> The New Portland Meadows (TNPM) moves for reconsideration of our opinion in *The New Portland Meadows v. Dieringer*, 153 Or App 383, 957 P2d 190 (1998), in which we held that TNPM was responsible for claimant's workers' compensation claim. TNPM asserts that we should have assigned initial responsibility to Vanport, a Washington employer, because it was the place of employment when claimant first sought medical treatment. TNPM argues that we then should have considered whether responsibility could be shifted forward to TNPM. It contends that responsibility cannot be shifted forward to it because "the evidence is undisputed that [TNPM's] employment did not worsen the condition[.]"

We stated in our opinion in this case that "the Board was correct in its initial assignment of responsibility to TNPM because it was the last employment that could have caused [claimant's] disease." TNPM argues that this is incorrect because Vanport was claimant's employer when she first sought medical treatment. We agree that our statement was incorrect. In reaching the above conclusion, we relied on the general rule, as stated most recently in *Roseburg Forest Products v. Long*, 325 Or 305, 937 P2d 517 (1997), that initial or presumptive responsibility under the last injurious exposure rule is assigned to the last period of employment whose conditions could have caused claimant's disability. We failed, however, to include in our analysis the refinement of this general rule that the onset of disability is the triggering date for determining which employment is the last potentially causal employment. If the injured worker receives medical treatment before experiencing time loss due to the condition, then, as TNPM correctly asserts, the date of first medical treatment determines which employer is assigned initial responsibility for the claim. *Reynolds Metals v. Rogers*, 157 Or App 147, 153, ___ P2d ___ (1998).

Vanport would ordinarily be the presumptively responsible employer because claimant first sought medical treatment while employed there, and we would assign initial responsibility to Vanport. A complicating factor here, however, is that Vanport is an out-of-state employer. In *Progress* **<157 Or App 621/622>** *Quarries v. Vaandering*, 80 Or App 160, 165-66, 722 P2d 19 (1986), we held that presumptive responsibility will not be assigned to an employer over which this state has no jurisdiction. Following that principle, Vanport may not be assigned initial responsibility.

TNPM argues that our decision in *UPS v. Likos*, 143 Or App 486, 924 P2d 857 (1996), requires a different result. TNPM asserts that *Likos* supports its argument that the fact that Vanport is an out-of-state employer does not prevent it from being designated as the initially responsible employer. *Likos* involved a claimant who first sought medical treatment while she was self-employed at Genesis Services, a business in which she, as the sole proprietor, chose not to be subject to the Workers' Compensation Act. The claimant sought to shift responsibility from Genesis Services to a later employer that was subject to the workers' compensation system. We concluded that the Board erred in assigning responsibility to the later employer because Genesis Services was the last potentially causal employment

before the claimant sought medical attention and, had it been a subject employer, it would have been responsible. However, our holding in *Likos* is not controlling here because, in contrast to the circumstances in *Progress Quarries* and here, the nonsubject employer in *Likos* was an employer under the jurisdiction of Oregon. The employer in *Likos* simply chose to take the risk of not being compensated for an on-the-job injury by not placing herself within the Oregon workers' compensation scheme.

We conclude that, under our holding in *Progress Quarries*, we cannot assign initial responsibility to Vanport, an out-of-state employer. Consequently, TNPM remains the only potentially responsible employer in this case. Under our holding in *Silveira v. Larch Enterprises*, 133 Or App 297, 891 P2d 697 (1995), the last injurious exposure rule continues to apply even if there is only one employer subject to Oregon's jurisdiction. Under *Silveira*, if claimant can establish that the employment with TNPM was injurious and provided "potentially causal" conditions for her condition, TNPM will be found to be the responsible employer. *Id.* at 302. TNPM could avoid responsibility here under the last injurious exposure rule by proving that conditions of its employment could not have caused the condition or that claimant's employment **<157 Or App 622/623>** at Vanport was the sole cause of the condition. *Roseburg*, 325 Or at 313. However, the Board found here that claimant's work activities at TNPM were "injurious," and that finding is supported by substantial evidence. We conclude that the Board did not err in holding that TNPM was the responsible employer.

Petition for reconsideration allowed; opinion modified and adhered to as modified.

Cite as 157 Or App 665 (1998) December 16, 1998

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jim R. Reed, Claimant.

JIM R. REED, Petitioner,
v.
LABOR FORCE OF OREGON and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(96-06663; CA A98353)

Judicial Review from Workers' Compensation Board.
On petitioner's Petition for Reconsideration filed September 10, 1998.
Opinion filed September 2, 1998. 155 Or App 595, ___ P2d ___.
James S. Coon and Swanson, Thomas & Coon for the petition.
Before Edmonds, Presiding Judge, and Armstrong, Judge, and Warden, Senior Judge.
ARMSTRONG, J.
Reconsideration allowed; original opinion adhered to.

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157 Or App 667> Claimant seeks reconsideration of our decision in *Reed v. Labor Force of Oregon*, 155 Or App 595, ___ P2d ____ (1998), in which we held that claimant was not entitled to temporary disability payments for the period between November 1, 1995, and March 12, 1996. Claimant contends that the proper disposition of the case would have been to "remand [it] so that the insurer can undertake to fulfill its legal obligation to verify and document temporary disability authorization."

Before the Board, claimant argued only that insurer should be required to pay temporary time-loss benefits as a penalty for failing to follow the applicable administrative rules. It was not until the matter was before us that claimant raised the possibility of remand for the purpose of requiring the insurer to verify claimant's disability. Because claimant did not seek from the Board the relief that he now seeks from us, we will not grant the requested relief.

Reconsideration allowed; original opinion adhered to.

Cite as 158 Or App 464 (1999) February 17, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Glenn E. Whitlock, Claimant.

GLENN E. WHITLOCK, Petitioner,
v.
KLAMATH COUNTY SCHOOL DISTRICT, Respondent.
(Agency No. 93-13776; CA A98297)

En Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted April 7, 1998; resubmitted en banc December 9, 1998.
Sean Lyell argued the cause for petitioner. On the brief were Ralph E. Wiser, III, and Bennett, Hartman, Reynolds & Wiser.
Elliot C. Cummins argued the cause for respondent. With him on the brief was Cummins, Goodman, Fish & Platt.
Before Deits, Chief Judge, and Warren, Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim and Kistler, Judges.
HASELTON, J.
Reversed and remanded for consideration of whether claimant's preparation time was the major contributing cause of his mental disorder.
De Muniz, J., dissenting.

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158 Or App 466> Claimant petitions for review of an order of the Workers' Compensation Board that determined that his mental disorder was not compensable because, *inter alia*, the work-related preparation that allegedly produced claimant's disorder was a "condition[] generally inherent in every working situation." ORS 656.802(3)(b).[1] We reverse and remand.

This case is before us for the second time. *Whitlock v. Klamath County School District*, 142 Or App 137, 920 P2d 175 (1996) (*Whitlock I*). Claimant taught music to elementary school children in the Klamath County School District (District) from 1981 until 1993. At the end of the 1992-93 school year, in the wake of Ballot Measure 5,[2] the employer District eliminated all elementary school music teaching positions. Consequently, claimant exercised his "bumping" rights under a collective bargaining agreement and secured a secondary school social studies teaching position with the District. Although claimant had a secondary social studies certification, he had never actually taught that subject.

For the 1993-94 school year, the District assigned claimant either six or seven class periods a day, in four subject areas: 7th grade social studies, 10th grade global history, 12th grade economics, and 12th grade federal government. Claimant, like all teachers in the District, was allotted one 49-minute preparation period a day.

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[1] ORS 656.802 governs the compensability of "occupational diseases." Under certain circumstances, a "mental disorder" is a compensable "occupational disease." ORS 656.802(1)(a)(B). ORS 656.802(3) provides, in part:

> "(3) Notwithstanding any other provision of this chapter, a mental disorder is not compensable * * * unless the worker establishes all of the following:
>
> "(a) The employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer * * *."

[2] Ballot Measure 5 was adopted by the electorate in 1990 and incorporated into the Oregon Constitution at Article XI, section 11b-11f.

Claimant felt overwhelmed and stressed by his new duties. He worked 12 to 14 hours a day, including spending <158 Or App 466/467> four to six hours a night preparing for the next day's classes. Nevertheless, he received "considerable" criticism from his students and some criticism from the school administration.[3] Claimant became very despondent and, at the urging of family and friends, sought treatment from his physician, who referred him for psychiatric treatment. The psychiatrist diagnosed "a single episode of nonpsychotic major depression due to stress at work."

In October 1993, claimant filed a claim for workers' compensation. Employer denied coverage. The administrative law judge set aside employer's denial and awarded claimant attorney fees. The Board, with one dissenting member, reversed, concluding that claimant had failed to prove a compensable mental disorder under ORS 656.802, because "the stressors that claimant cites are all conditions which are generally inherent in every working situation." In so holding, the Board focussed on conditions that led to claimant assuming the social studies position--*i.e.*, employer's budgetary constraints and claimant's exercise of "bumping" rights--as well as claimant's alleged lack of training.[4] The Board did not, however, meaningfully address the actual employment conditions--*i.e.*, "lack of preparation time" and the consequent requirements of extensive off-duty preparation--that claimant asserted produced his disorder.

On review in *Whitlock I*, we reversed and remanded. We agreed with claimant that "the Board's analysis of the conditions that led to claimant assuming the social studies position was extraneous," 142 Or App at 143, and that the Board's "preoccup[ation] with the prevalence of layoffs and the dynamics of bumping rights * * * may well have skewed [its] passing consideration of the preparation demands of the social studies position." *Id.* We further concluded:

> 158 Or App 468> "[T]he Board's discussion of the preparation demands associated with the social studies position was so cursory as to preclude meaningful judicial review * * *. [N]othing in the Board's extended analysis * * * suggests that the Board actually, specifically considered whether the preparation for the social studies position was of a sort 'generally inherent in every working situation.' Much less does the Board's decision explain why it could, or would, have reached such a conclusion." *Id.* at 143-44.[5]

On remand, the Board concluded that claimant's mental disorder was not compensable because his job preparation was a "condition generally inherent in every working situation":

> "[T]he assumption of a new job ordinarily will result in extra work hours gaining experience and proficiency. Under certain circumstances, the extra work preparation time may be deemed excessive and, hence, not a condition common to all employments. Under the circumstances of this case, however, we find that claimant's extra preparation time was not excessive. Claimant was adequately trained for the teaching position because he had over 10 years of actual teaching experience and possessed a secondary social studies teaching certificate. Although his teaching experience was in music education at the elementary school level, we are persuaded that the teaching skills he gained at the elementary level were largely transferable to the secondary level. In addition, claimant's teaching certificate established that he had the minimum level of proficiency required to teach secondary social studies.

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[3] The parties stipulated that claimant's interaction with school administrators falls into the category of "reasonable disciplinary, corrective or job performance evaluation actions," ORS 656.802(3)(b), and is not the basis of his cliam.

[4] With respect to claimant's alleged lack of training to teach social studies, the Board observed:

> "Because of claimant's eleven years of experience as a teacher and his demonstrated 'proficiency' in social studies (sufficient to warrant certification in that subject area), we are not persuaded that, in claimant's case, there was such a lack of training."

[5] In *Whitlock I*, claimant did not specifically assign error to the "inadequate training" portion of the Board's order. In our discussion, we observed that the claimant had also asserted that "inadequate training" caused his stress but noted that "the Board concluded that, because of claimant's certification in social studies, there was no lack of training." 142 Or App at 141 n 3.

"Claimant's assumption of the new teaching position brought with it the expectation that he would devote extra preparation time to gain proficiency in the teaching position. This was particularly true given the fact that claimant had no practical teaching experience at the secondary level and his teaching experience was limited to music education. Both the subject matter and the older students were **<158 Or App 468/469>** more demanding than what claimant had previously experienced as an elementary music teacher. *Under circumstances such as these, where a worker assumes a new position in the same occupation (e.g., teaching) and has met the minimum level of proficiency required to perform the tasks of the new position, we conclude that it is a condition common to all employments for the worker to devote extra time and efforts gaining proficiency in the position.*

"The number of hours that claimant spent preparing for his social studies classes (*i.e.*, 12 to 14 hours including four to six hours at home) was significant, particularly when compared to his preparation time as an elementary music teacher. Yet, when properly viewed in the context of commencing a new position, an event that commonly occurs in all employments, those number of hours do not appear to be unusual. Claimant was not directed by the employer to work or prepare for long hours. At the same time, though, he had begun the first term of his new teaching position and should reasonably have expected to devote extra hours during the first term gaining experience and proficiency; it was during this transitiion period that claimant first sought treatment for depression.

"We *find that claimant's extra hours of preparation was a condition 'generally inherent in every working situation' and, therefore, may not be considered a condition producing his mental disorder.*" (Emphasis added.) (Footnotes and citations omitted.)[6]

Claimant again seeks review, raising two assignments of error: (1) The Board erred in finding that claimant's job-related preparation was a condition "generally inherent in every working situation." ORS 656.802(3)(b). (2) The Board erred in finding that claimant did not lack training for his new position in a "real and objective sense." ORS 656.802(3)(a).

With respect to the first assignment of error, claimant asserts that preparation, much less substantial off-duty **<158 Or App 469/470>** preparation, is not "generally inherent in every working situation"--and that, "[i]n fact, many occupations probably involve no off-duty preparation time at all."[7] Moreover, claimant contends, the amount of his off-duty preparation time "is a work condition found in extremely few jobs."

Employer counters that claimant's identification of the operative "condition" for purposes of the statutory analysis--"off-duty preparation time of four to six hours every day"--is impermissibly narrow and begs the question in that it frames the inquiry in terms of claimant's particular circumstances rather than general conditions of employment. That is, employer argues, the proper inquiry is not whether extra preparation of four to six hours a day is "a condition generally inherent in every working situation" (obviously, it is not),[8] but whether work preparation, in general, is such a condition. Employer further asserts that the Board's identification and definition of the operative "employment condition"--*i.e.*, how broadly or narrowly to characterize that condition--is a matter within the Board's particular expertise and "discretion" to which "deferrence" is owed.

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[6] In a footnote, the Board reiterated its previous determination that,

"[b]ased on claimant's substantial teaching experience and secondary social studies teaching certificate, * * * [his] asserted lack of training for the secondary teaching position was not a condition that existed in a 'real and objective sense.'"

[7] Claimant lists as examples: secretaries, receptionists, pizza delivery persons, firefighters, sales representatives, assembly line workers, loggers, grocery clerks, "middle managers," waiters, cooks, field workers, and librarians.

[8] We reiterate our observation in *Whitlock I* that

"[e]mployer does not dispute that the conditions cited by claimant--*i.e.*, the need to prepare for four distinct classes and the lack of sufficient time for such preparation--exist in a real and objective sense." 142 Or App at 141 n 4.

Thus, we assume that claimant's off-duty preparation was necessary, as reasonably related to the requirements of his work.

Central to each party's position, and to our analysis, is *Fuls v. SAIF*, 321 Or 151, 894 P2d 1163 (1995), the only Supreme Court case construing and applying ORS 656.802(3)(b). In *Fuls*, the claimant was a service station attendant who suffered a conversion reaction after a customer gave him an unexpected bear hug. The Board determined that that condition was not compensable because "[v]irtually every working situation involves some degree of interaction with co-employees and/or the public" and that the bear hug that the claimant received was not "outside the range of behavior that occurs in every working situation." We **<158 Or App 470/471>** affirmed that determination. *Fuls v. SAIF*, 129 Or App 255, 879 P2d 869 (1994).

On review, the Supreme Court also affirmed. In so holding, the court construed ORS 656.802(3), exploring the seeming tension between "*generally* inherent" and "*every* working situation." After concluding that "'every' and 'generally' as used in the text have somewhat conflicting meanings, and the context sheds no light on the legislature's intent," 321 Or at 160, the court canvassed the legislative history:

> "ORS 656.802(3) was amended significantly by House Bill 2271 in 1987, adding the criterion regarding 'conditions generally inherent in every working situation.' Or Laws 1987, ch 713, section 4. As introduced, this provision indicated that 'a mental disorder is not compensable under this chapter * * * unless the employment conditions producing the psychologic stress are extraordinary in nature.' At a public hearing, it was suggested that the term 'extraordinary' was too vague and, as a result, the House Committee on Labor amended the phrase to read: 'Unless the employment conditions producing the mental disorder are conditions other than conditions inherent in every working situation.' * * * In response to other concerns brought out at public hearings, that the 'inherent in every working situation' language was too narrow, the Senate Committee on Labor added the qualifier of 'generally' to the beginning of the phrase. Senator Hill said that this change was proposed, because the current language would make it difficult for employers to defend mental disorder claims; it would be impossible to demonstrate that a condition was inherent in absolutely *every* working situation." 321 Or 151 at 160-61 (emphasis in original) (citations omitted).

From that history, the court divined that the "legislature intended to curtail compensable claims for mental disorders based on on-the-job stressors." *Id.* at 161. Thus, a work-related mental disorder is not compensable if the stress-inducing condition is common to the general range of employments, even if that condition is not necessarily inherent in every job. *See Housing Authority of Portland v. Zimmerly*, 108 Or App 596, 599, 816 P2d 1179 (1991) ("The legislature intended to preclude claims for mental disorders that arise from conditions that are common to all employments.").

158 Or App 472> The court then considered the specific merits of the Board's decision and, in so doing, announced the standard of judicial review: Was the Board's decision that the claimant's mental disorder was the result of "conditions generally inherent in every working situation" "within the legislative policy that inheres in [that] statutory term"? 321 Or at 162. The court concluded:

> "Human interactions are 'conditions generally inherent in every working situation.' Although the amount and type of interaction with supervisors, coworkers, or customers may vary depending on the type of working situation, some interaction is inherent. Human interaction involves greeting.
>
> "* * * * *
>
> "We affirm the Board's characterization of this type of conduct by a person with whom one is expected to interact in the workplace, which does not result in a physical injury, as a condition that is 'generally inherent in every working situation.'" *Id.* at 162-63 (footnotes and citations omitted).

Here, employer argues that *Fuls* requires us to consider "the *general* nature" of the alleged stressor, and "not the *specific or unique* nature of the particular event" experienced by the claimant (preparation time of four to six hours every day). In employer's view, the Supreme Court in *Fuls* purposely placed the bear hug in the broadest possible category ("human interaction") so as to effectuate

the legislature's intention to curtail compensable mental disorder claims. Conversely, claimant invokes *Fuls*, and the legislative history quoted in that opinion,[9] for the proposition that, even if **<158 Or App 472/473>** substantial off-duty preparation is required for teaching positions generically, such preparation is not a condition "generally inherent in every working situation":

> "The *Fuls* Court made clear that the phrase 'generally inherent in every working situation' refers to those conditions that all workers may experience in their jobs, such as human interactions, following the rules of the job, termination, etc. The legislature did not intend for the phrase to be job-specific. Thus, even if every person in a certain profession experiences a certain work condition, that does not mean that all persons in every working situation experience that work condition."

Each party is correct--to a point. Employer is correct that, because no two cases are identical, the operative "condition" cannot be defined solely and specifically by reference to a claimant's particular circumstances.[10] Claimant is correct that the statutory inquiry focuses not on the work conditions of teachers, or even professionals, generally, but on the complete range of employments.

158 Or App 474> Nevertheless, the parties' arguments overshoot their mark. *Fuls* does not, as employer implies, purport to sanction, much less compel, characterizing the operative work condition in such broad terms as to preclude the compensability of work-related mental disorders. Indeed, in the abstract, if categories are drawn sufficiently broadly, virtually any stress-inducing employment condition could be characterized as a sub-species of a much broader condition common to all employments. Such an approach would not merely "curtail," but would preclude, compensability. Nor, as claimant suggests, did the Board frame its analysis in terms of the requirements of the particular employment--teaching, and teachers, only. Rather, the Board described the operative "condition" generally, as follows:

> "[W]here a worker assumes a new position in the same occupation * * * and has met the minimum level of proficiency required to perform the tasks of the new position, we conclude that it is a condition common to all employments for the worker to devote extra time and efforts gaining proficiency in the position."

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[9] In *Fuls*, 321 Or at 161-62 n 9, the court reproduced the follow colloquy:

"[REPRESENTATIVE SHIPRACK:] Sub b says that they've got to be conditions other than those conditions inherent in any, pardon me, in every working situation. So that means that they would have to be something that everyone would, everyone would agree are inherent to what you see everyday in the workplace.

"[SENATOR HANNON:] If I may stop you just for a moment, Representative. Could that same sort of standard be used for office worker versus say like a firefighter? Would the same basis, standard, apply in the workplaces?

"[REPRESENTATIVE SHIPRACK:] The intent there, Senator, is that in the workplace, you are expected to show up on time, you are to cooperate, perhaps, with your fellow employees, you are expected to have certain things unrelated to the specific occupations involved. This may also address itself to the fact that perhaps in every, in every experience you will have times of layoff. It does not--the intent of this is not to say a firefighter has a more stressful job than someone digging ditches, perhaps, although occasionally * * * be that way. We didn't want to get into that. That's not the intent of the House, to say that this profession is something, and this isn't. But there are certain duties in the workplace that are inherent to every job. And that's what we're trying to say there.

"* * * * *

"[REPRESENTATIVE SHIPRACK:] We're not getting rid of stress disabilities in this bill, as some people may have said. We're not repealing stress disabilities. *What we are doing, we are certainly tightening it up.* I will grant you that. I think it, perhaps, in a few random cases, it has, there has been some problems. In the definitions, what you see in sub b is one thing that, I guess, is probably the part of the definition that will do the most to clarify what the intent of the House is." Public Hearing, Senate Committee on Labor, April 23, 1987, Tape 120, Side A (emphasis added)."

[10] Where, however, the stress-inducing employment conditions are tortious, or so extreme as to be beyond the range reasonably contemplated in employment, the resulting mental disorder is compensable even if conditions producing that disorder could be characterized, more generally, *e.g.*, as "human interaction." *See Fuls*, 321 Or at 162 (bear hug was not tortious because it was "a greeting * * * which lacked any intent on the part of the customer to bring about harm"). *Cf. Bank of Newport v. Wages*, 142 Or App 145, 919 P2d 1189 (1996) (affirming determination that the claimant's adjustment disorder, which was caused by supervisor's and co-employee's ridicule, taunting, and "joke" about claimant's obesity, was compensable).

We review that determination to determine whether it "appears to be within the legislative policy that inheres in the statutory term." *Fuls*, 321 Or at 162.[11] We conclude that it does not.

158 Or App 475> The legislative intent underlying ORS 656.802(3)(b) is somewhat amorphous: Although the legislature intended to "curtail compensable claims for mental disorders based on on-the-job stressors," *Fuls*, 321 Or at 161, it intended to do so only if, or to the extent that, the stress-producing condition was common to the full range of employment. In this case, the Board's decision did not comport with that intent because "devot[ing] extra time and efforts gaining proficiency in [a new] position" is not common to the full range of working situations. Indeed, many jobs do not require "extra time and effort"--efforts beyond the on-the-job performance of the work itself--to attain proficiency. That is, most jobs do not require off-duty preparation, much less "extra hours of preparation time," to perform the work competently. For example, such common occupations as food preparation and serving, manual farm work, construction work, and manufacturing and fabricating work, generally do not involve "extra" preparation distinct from on-the-job performance.[12]

The Board erred in determining that the off-duty preparation that claimant had to undertake to perform his job competently was a condition "generally inherent in every working situation." We reverse that determination. That does not, however, resolve whether claimant's mental disorder was compensable. Because the Board determined that claimant's off-duty preparation was "generally inherent in every working situation," it did not consider whether that employment condition was, in fact, the major contributing cause of claimant's mental disorder. *See* ORS 656.802(2)(a). We remand to the Board to determine that question in the first instance.

In his second assignment of error, claimant challenges the Board's conclusion that his alleged lack of training for his position did not exist in a "real and objective sense." ORS 656.802(3)(a). That question was, however, beyond the scope of our remand in *Whitlock I*:

> "We * * * conclude that the Board failed to 'articulate * * * the rational connection between the facts and the legal **<158 Or App 475/476>** conclusion' that the preparation associated with claimant's social studies position was of a sort 'generally inherent in every working situation.' * * * Accordingly, we reverse and remand for the Board to address that question." 142 Or App at 144.

In so remanding, we rejected, albeit implicitly, claimant's "lack of training" arguments raised in *Whitlock I*. *See* 142 Or App at 141 n 3. Accordingly, we reject claimant's second assignment of error. *See Alexander v. U.S. Tank & Construction Co., Inc.*, 130 Or App 590, 593, 883 P2d 858 (1994) (declining to address conclusions of law challenged in second appeal that were beyond scope of remand after first appeal).

Reversed and remanded for consideration of whether claimant's preparation time was the major contributing cause of his mental disorder.

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[11] Contrary to employer's assertion, that determination is not "within the range of discretion granted to the Board by the legislature," which must, consequently, "be given difference." Neither of the cases that employer cites, *Booth v. Tektronix, Inc.*, 312 Or 463, 823 P2d 402 (1991) or *SAIF v. Campbell*, 113 Or App 93, 830 P2d 616 (1992) supports that proposition. In *Booth*, the court merely addressed the standard for reviewing the Board's promulgation and interpretation of its own rules adopted pursuant to a "policy-delegating statute." 312 Or at 472-74, (quoting *Springfield Education Assn. v. School Dist.*, 290 Or 217, 229, 621 P2d 547 (1980)).

In *Campbell*, a pre-*Fuls* decision, we considered, and rejected, the employer's argument that the Board "erroneously supplied evidence by 'going outside the record' to determine what work conditions are generally inherent in every working situation." 113 Or App 96. Although we did state that, "[u]nder the statute, the Board is authorized to develop the standard, that is, what 'conditions [are] generally inherent in every working situation,' either by formal rule making or on a case-by-case basis," 113 Or App at 96, we referred neither to deference nor to "discretion." We emphasize, moreover, that "employer has not argued that the Board's interpretation of the statute is inconsistent with the legislature's intent." *Id.* That argument, which corresponds to the standard of review announced in *Fuls*, is precisely the argument that claimant now makes.

[12] *See, e.g., Occupational Projections and Training Status* (U.S. Dept. of Labor, Bureau of Labor Statistics, Bulletin 2451 39-42 (1994) (listing over 200 job categories in which "work-related or post-secondary school training is not significant")).

DE MUNIZ, J., dissenting.

The majority concludes that the Board erred in its interpretation of the "condition[] generally inherent in every working situation" in ORS 656.802(3)(b). In so holding, the majority misconstrues the Board's order, which states:

> "[T]he assumption of a new job ordinarily will result in extra work hours gaining experience and proficiency. Under certain circumstances, the extra work preparation time may be deemed excessive and, hence, not a condition common to all employments. * * *
>
> "Claimant's assumption of the new teaching position brought with it the expectation that he would devote extra preparation time to gain proficiency in the teaching position. * * * Under circumstances such as these, *where a worker assumes a new position in the same occupation (e.g., teaching) and has met the minimum level of proficiency required to perform the tasks of the new position, we conclude that it is a condition common to all employments for the worker to devote extra time and efforts gaining proficiency in the position.*
>
> "[W]hen properly viewed in the context of commencing a new position, an event that commonly occurs in all employments, those number of hours [spent by claimant] do not appear to be unusual." (Emphasis added.)

158 Or App 477> Based on the emphasized language, the majority concludes that the Board determined the inherent condition to be devoting extra time and effort to gain proficiency in a new position. Or App at 474. However, when all of the order is considered, the common condition identified by the Board is not extra time and effort but, rather, the "learning curve" present in any new employment with the attendant expectation that a worker will do the preparation needed to perform the job.

The majority does not recognize a learning curve as a condition common to any new employment. Instead, it focusses solely on off-duty efforts needed to gain proficiency. The majority points to a laundry list of jobs found in the newspaper classifieds, which, it says, do not require off-duty efforts to become proficient and, therefore, shows that such efforts cannot be common to all employments.[1]

I do not dispute that many jobs require little or no off-duty time or effort to do them competently. But the majority's focus misses the common condition recognized by the Board. A dishwasher may not have to spend off-duty time and effort to become competent at a new dishwashing job. However, that does not mean that there is no learning curve in that new job. A learning curve exists even if it might be limited to learning the physical layout, the routine of the staff, or employer expectations for the job.

I do not conclude, as does the majority, that the Board's order states that every new job requires off-duty time and effort. Rather, it shows the Board's understanding that, depending on the nature of the job and the qualifications brought to it, a worker may--or may not--be required to spend off-duty time and effort to become proficient at a new job. Articulated in terms addressing claimant's circumstances, the Board recognized that where, as here, claimant's **<158 Or App 477/478>** prior teaching experience in elementary school music education gives him only "minimal proficiency" for the new position, the "learning curve" of teaching social studies at the secondary level will require off-duty time and effort in order to gain proficiency.[2]

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[1] Even assuming that the majority is correct that lifeguards, delivery drivers, painters, or shipping handlers do not spend off-duty time in job preparation, the majority does not explain why it picks those occupations as opposed to teachers, accountants, stock brokers, lawyers, computer programmers or, for that matter, judges, whose professions do demand off-duty efforts to gain proficiency.

[2] The Board clearly understood that there are situations when the required proficiency of a new position goes beyond constituting a "learning curve" and will result in excessive preparation. In claimant's instance, however, the Board rejected that that was the case. Claimant's second assignment of error essentially challenges that finding, but I agree with the majority that that issue was beyond the scope of remand.

The majority recognizes that "a work-related mental disorder is not compensable if the stress-inducing condition is common to the general range of employments, even if that condition is not necessarily inherent in every job." 158 Or App at 471. Despite that recognition, the majority's approach demands that the condition be present in every job and focuses the dispute exactly where the legislature did not want it. Legislative history cited by the Supreme Court in *Fuls v. SAIF*, 321 Or 151, 160-61, 894 P2d 1163 (1995), shows that the qualifier "generally" in ORS 656.802(3)(b) was added precisely because the legislature recognized the impossibility of demonstrating that a condition would be inherent in absolutely every working situation.

Our role on review is to decide whether the Board's determination "appears to be within the legislative policy that inheres in the statutory term." *Fuls*, 321 Or at 162. The Board's identification of the presence of a learning curve in new employment is a condition common to the general range of employments. The Board's interpretation is, thus, within the legislative policy of a condition "generally inherent in every working situation," ORS 656.802(3)(b), and the majority errs in holding otherwise.

I dissent.

Warren, Edmonds and Linder, JJ, join in this dissent.

Cite as 158 Or App 639 (1999) February 24, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Laurel A. Nelson, Claimant.

ALLIED SYSTEMS CO. and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
LAUREL A. NELSON, Respondent.
(96-04100; CA A99507)

Judicial review from Workers' Compensation Board.
Argued and submitted June 3, 1998.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Linda C. Love argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

*Deits, C. J., *vice* Riggs, J., resigned.

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158 Or App 641> Employer seeks review of an order of the Workers' Compensation Board, asserting that the board erred in reversing the administrative law judge and finding that claimant's carpal tunnel syndrome is a compensable occupational disease and in assessing a 25 percent penalty for employer's alleged untimely denial of claimant's claim. We affirm, without discussion, the Board's finding that claimant's condition is work related. We write only to discuss employer's contention that the Board erred in assessing a penalty.

Claimant, who worked for employer as a secretary, first sought treatment for pain and numbness in both hands in December 1995. She told employer about the problem on December 4, 1995. On December 20, 1995, Dr. Stevens authorized modified work without typing. Employer made some efforts to accommodate that request. On Form 801, which claimant submitted on January 15, 1996, employer was required to indicate the "[d]ate employer first knew of injury or occupational disease," and employer filled in "12-04-95." On April 10, 1996, employer denied the compensability of claimant's condition. The Board found that the claim was compensable and that employer had notice of the "claim" in December 1995. The Board further found that employer offered no explanation for the untimeliness of its denial of the claim; accordingly, it assessed a penalty.

ORS 656.005(6) defines a claim as "a written request for compensation from a subject worker or someone on the worker's behalf, *or any compensable injury of which a subject employer has notice or knowledge.*" (Emphasis added.) In construing the statute, our task is to discern the intent of the legislature by first examining its text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 859 P2d 1143 (1993). The Supreme Court has said that the definition of "claim" in ORS 656.005(6) refers to two "disjunctive" events: (1) a "written request for compensation" or (2) the employer's notice or knowledge of a compensable injury. *SAIF Corp. v. Allen*, 320 Or 192, 201, 881 P2d 773 (1994). Only the employer's notice of a "claim" triggers the procedures set forth in ORS 656.262 for acceptance, denial, and payment of **<158 Or App 641/642>** benefits and for the assessment of penalties should the employer improperly proccess the claim. Thus arises the significance of the Board's finding that employer had notice of the claim by December 1995.

Employer asserts that the Board could not have meant that by December 1995 employer had notice of the "claim" in the sense of a written request for compensation, because claimant did not indicate in writing that she was seeking compensation until she completed Form 801 in January 1996. Further, employer argues, although employer was aware of claimant's condition as early as December 4, 1995, it did not have knowledge that the condition was work related as of that date. Therefore, it contends, it did not have notice of the claim in the second sense described in ORS 656.005(6), notice or knowledge of "a compensable injury."

The outcome of this case depends entirely on the second definition of "claim," which, in turn, incorporates the term "compensable injury." ORS 656.005(7)(a) defines a "compensable injury" in pertinent part as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" That definition is applicable unless the context requires otherwise. ORS 656.003. Thus, the second type of claim described in ORS 656.005(6) is an accidental injury arising out of and in the course of the employment of which the employer has notice or knowledge.

For the purpose of the issue in this case, the incorporation of the definition of compensable injury does not lend significantly to the clarity of the statute. The text of the statute, with the definition of compensable injury, still leaves some questions to be resolved. If, as here, the employer challenges the claimant's contention that the injury is work related, is the injury of which the employer has notice or knowledge a claim under the second definition of ORS 656.005(6)? Is an injury that is at first denied but ultimately determined through litigation to be compensable a claim under ORS 656.005(6)? The answer to both questions would be "yes," if guidance is to be taken from the Supreme Court's recent opinion in *Armstrong v. Rogue Federal Credit Union*, 328 Or 154, 328P2d 154 (1998). There, the court considered **<158 Or App 642/643>** whether an employer commits an unlawful employment practice under ORS 659.415 by denying an injured worker's demand for reinstatement during the pendency of litigation over whether the worker's injury is compensable. ORS 659.415 provides a right to reinstatement upon demand to a worker who has sustained a "compensable injury." At the time she demanded reinstatement, Armstrong's workers' compensation claim was disputed by the employer. The employer argued that reinstatement is available only to the worker whose injury is in compensable status at the time of the demand for reinstatement. The court applied to ORS 659.415 the definition of "compensable injury" in ORS 656.005(7). The court said:

> "Generally, a 'compensable injury' is an accidental injury that 'arises out of and in the course of employment.' When a worker is injured at work, the injury is a compensable injury under ORS 656.005(7)(a) from the moment of its occurrence, even if the insurer denies that the injury is compensable, and even if the administrative and judicial systems take months or years to determine the validity of the employer's denial. Nothing in the statutory definition of 'compensable injury' in ORS 656.005(7)(a) indicates that the definition refers only to an injury that the Board and the courts, after exhaustion of all legal proceedings, have determined to be work-related."

328 Or at 159. The court held that an employer's obligation to reinstate an injured worker is not contingent on an early determination of compensability. Thus, the employer has the same obligation to offer reinstatement when the injury claim is denied as it has to offer reinstatement when the claim is accepted.

The quoted language from the Supreme Court's opinion lends support to the view that "compensable injury," as defined in ORS 656.005(7) and as used in ORS 656.005(6), does not mean that the injury must be known to be compensable at the time of notice of the claim and does not excuse the employer from processing as a claim an injury that it asserts is not work related. Further, the context of ORS 656.005(6) shows clearly that the existence of a claim, and the employer's obligation to process it, are not contingent on the **<158 Or App 643/644>** employer's knowledge at the time of the injury that the claim is compensable.

A claimant must give the employer notice of an injury, as required by ORS 656.265:

> "(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. The employer shall acknowledge forthwith receipt of such notice.
>
> "(2) The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, *concerning an accident which may involve a compensable injury* shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement."

(Emphasis added.) To satisfy the notice requirement, it is sufficient to provide a written report from the claimant or the claimant's doctor concerning an accident that may involve a compensable injury.

Despite the requirement for written notice, the 90-day period for the issuance of a notice of acceptance or denial and for the processing of the claim is also triggered by the employer's "knowledge" of the claim:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has *notice or knowledge of the claim.*"

ORS 656.262(6)(a) (emphasis added). The "notice or knowledge" language is used throughout ORS 656.262. ORS 656.262(2) provides that

> "[t]he compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving *notice or knowledge of a claim,* except where the right to compensation is denied by the insurer or self-insured employer.
>
> **158 Or App 645>** "(3) Employers shall, immediately and not later than five days after *notice or knowledge of any claims or accidents which may result in a compensable injury claim,* report the same to their insurer. * * *
>
> "(4)(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has *notice or knowledge of the claim,* if the attending physician authorizes the payment of temporary disability compensation."

Under subsection (3), the employer has a duty to report to its insurer any claim or accident, of which it has "notice or knowledge," that "may" result in a compensable injury claim. Subsection (4) requires payment of the first installment of temporary disability no later than the 14th day after "notice or knowledge" of the claim. Thus, all references to "notice or knowledge" in ORS 656.262 refer to notice or knowledge of the claim. There is no requirement in ORS 656.262 that the employer have knowledge that the injury itself is compensable.

If the existence of the second type of claim described in ORS 656.005(6) were contingent on the employer's knowledge of actual compensability, then much of ORS 656.262 would be superfluous. For example, if an injury is a claim only if it is compensable, then there is no need to provide an opportunity, under ORS 656.262(6)(a), for written notice of acceptance or denial of the claim within 90 days after the employer has notice or knowledge of the claim. The entire process set forth in ORS 656.262 contemplates an opportunity to establish or challenge the compensability of an injury after the filing of a claim, not as a prerequisite to it.

Further, the standard set out in ORS 656.265(4)(a) for the processing of a claim when notice of the claim is untimely is consistent with the view that the claim need not be known to be compensable to trigger the employer's processing obligation. ORS 656.265 provides that

> "(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 * * *."

158 Or App 646> (Emphasis added.) So long as the employer had "knowledge of the injury" within the prescribed time, an untimely claim must be processed. ORS 656.265(4). We have considered what type of information an employer must know in that context and have held that the employer's knowledge of the injury

> "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."

Argonaut Ins. Co. v. Mock (A41801), 95 Or App 1, 5, 768 P2d 401, *rev den* 308 Or 79 (1989). Thus, for the purpose of determining whether a claimant may pursue an untimely claim, the question is whether, within one year of the injury, the employer had knowledge of "enough facts as to lead a reasonable employer to conclude that workers' compensation liability *is a possibility*." *Id.*; (emphasis added).

The effect of the legislature's use of the word "compensable" has come up in other contexts. ORS 656.005(8) defines compensation as "all benefits * * * provided for a *compensable* injury." (Emphasis added.) In *Jones v. Emanuel Hospital*, 280 Or 147, 570 P2d 70 (1977), the Supreme Court decided that, despite the statement in the statute that benefits are paid for injuries that are "compensable," compensation includes "interim compensation," to be paid beginning on the 14th day after notice or knowledge of the claim but before the employer has denied or accepted the claim, and interim compensation must be paid on all claims that are not yet denied or accepted, including those that are ultimately determined not to be compensable. An injury that is claimed to be work related need not be compensable in order to give rise to a right to benefits for time loss pending acceptance or denial of the claim.

We made an analogous holding in *Stanley Smith Security v. Pace*, 118 Or App 602, 848 P2d 1218, *rev den* 317 **<158 Or App 646/647>** Or 272 (1993), where we considered whether interim compensation must be paid on an aggravation claim that is ultimately determined not to be compensable. ORS 656.273(6) provides that compensation

> "shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a *compensable* worsening * * *."

(Emphasis added.) We held that, despite the statutory language requiring a "compensable" worsening, the context indicated a legislative intent that interim compensation be paid on all aggravation claims alleging an aggravation. We and the Supreme Court have thus held that in those two contexts the employer's processing obligation under ORS 656.262 is not contingent on the substantive compensability of the claim.

Similarly, here, we conclude that the second definition of "claim" in ORS 656.005(6) does not make the existence of a claim contingent on the employer's knowledge of actual compensability. Rather, the legislature chose to use the phrase "a compensable injury of which the employer has notice or knowledge" to draw a distinction between an injury for which a written claim for compensation had been filed and an allegedly work related injury that the employer learns of through other means. In the latter instance, the context of ORS 656.005(6) shows that the employer's obligation to investigate or issue an acceptance or denial is triggered by notice or knowledge of an *allegedly* compensable injury.

Here, employer marked on the Form 801 that it first knew of claimant's claim for an "occupational disease" on December 4, 1995. An occupational disease is one that arises out of the employment. It is treated as an injury. ORS 656.804. Although employer may have disputed at that time that claimant's condition was work related, the Board could reasonably infer from employer's notation on the Form 801 that employer knew in December 1995 that claimant was seeking compensation for an allegedly work related condition and thus had notice of a "claim." The Board found further that employer gave no explanation for the untimeliness of its denial. Employer does not challenge that finding. **<158 Or App 647/648>** Accordingly, we affirm the Board's determination that employer unreasonably delayed its denial of the claim.

Affirmed.

Cite as 158 Or App 654 (1999) March 3, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

TERRY B. MCCARTHY, Appellant,

v.

OREGON FREEZE DRY, INC., an Oregon corporation, Respondent.

(93-0020; CA A87840)

On remand from the Oregon Supreme Court, *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, *on recons* 327 Or 185, 957 P2d 1200 (1998).

Appeal from Circuit Court, Linn County.

Daniel R. Murphy, Judge.

Submitted on remand June 26, 1998, and on Motion by Robert C. Wyatt, Inc., for Permission to Appear Amicus Curiae filed May 14, 1998.

Nickolas Facaros, Gildea & Facaros and Emmons, Kropp, Kryger, Alexander, Egan & Allen for appellant.

William F. Gary, Judith Giers, Emily K. Newton and Harrang Long Gary Rudnick for respondent.

Bruce H. Orr and Meyer & Wyse, LLP, for motion.

Before Haselton, Presiding Judge, and Landau and Armstrong, Judges.

LANDAU, J.

Motion of Robert C. Wyatt, Inc., to appear as *amicus curiae* denied; respondent's petition for attorney fees granted in the amount of $12,000.

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158 Or App 656> On remand from the Supreme Court, we are required to re-examine and explain the basis for our award of attorney fees to defendant. Based on the rule acknowledged in the line of cases culminating in *Schlumberger Technologies, Inc. v. Tri-Met*, 145 Or App 12, 21 n 9, 929 P2d 331 (1996), *rev den* 325 Or 80, *modified on other grounds* 149 Or App 316, 942 P2d 862 (1997), we adhere to our previous award of $12,000.

Plaintiff sued defendant for, among other things, unlawful employment practices under ORS 659.121. Plaintiff then filed a voluntary notice of dismissal under ORCP 54 A(1), and the trial court entered a judgment of dismissal. Plaintiff later moved to set aside the dismissal for excusable neglect under ORCP 71 B. The trial court denied the motion, concluding that the mistake alleged--failure to "Shepardize" a key case--was not excusable. Plaintiff appealed, we affirmed without opinion, and the Supreme Court eventually denied review. *McCarthy v. Oregon Freeze Dry, Inc.*, 142 Or App 595, 922 P2d 729, *rev den* 324 Or 322 (1996).

After we affirmed without opinion, defendant petitioned for $18,268 in attorney fees under ORS 659.121(1), arguing: (a) that, contrary to our holdings in the *Schlumberger* line of cases, all it needed to show to be entitled to an award was that it was the prevailing party; and (b) that even if it also had to show that plaintiff's arguments were frivolous, it had done so. Plaintiff had two types of objections. First, plaintiff objected to the amount of the fees on the grounds that the total hours billed for writing the brief were excessive and that plaintiff should not have to pay for the hours that defendant's attorneys spent in "getting up to speed." Second, plaintiff objected to any fees being awarded on the ground that it was impossible to tell whether the underlying unlawful employment practices action was frivolous because no decision was ever made on the merits. We agreed with the first set of objections, but not with the objection to the fee award in general. Consequently, we issued an order awarding attorney fees, but in the amount of $12,000 rather than $18,268. However, we did not explain the basis for that award.

158 Or App 657> Plaintiff petitioned for review of the attorney fee award on several grounds, including that ORS 659.121, as we previously construed it, *see Schlumberger Technologies*, 145 Or App at 21 n 9, only allows a prevailing defendant to recover attorney fees if the plaintiff's claim was frivolous. The Supreme Court concluded that that construction of ORS 659.121 was a permissible one, but found it impossible to tell whether we had, in fact, made our decision on that basis. Accordingly, the Supreme Court vacated our award of attorney fees and remanded the case to us for further proceedings. *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 84, 957 P2d 1200 (1998). After reconsidering that decision on its own motion, the Supreme Court further clarified our task on remand as "describ[ing] the relevant facts and legal criteria for the court's decision * * * in any terms that are sufficiently clear to permit meaningful appellate review." *McCarthy v. Oregon Freeze Dry, Inc.*, 327 Or 185, 190-91, 957 P2d 1200 (1998).

We now clear up the confusion by rejecting defendant's invitation to nullify the line of cases culminating in *Schlumberger Technologies*, but accepting defendant's contention that plaintiff's arguments in favor of the motion to set aside were frivolous, unreasonable, or without foundation. At the outset, we note that Robert C. Wyatt, Inc., has moved for permission to appear as *amicus curiae* in this portion of the appeal. We do not believe that such an appearance would aid us in deciding the case at hand and, therefore, deny the motion.

ORS 659.121(1) provides, in part, "[i]n any suit brought under this subsection [allowing actions for unlawful employment practices], the court may allow the prevailing party costs and reasonable attorney fees at trial and on appeal." Beginning in *Dobie v. Liberty Homes*, 53 Or App 366, 632 P2d 449 (1981), we have held that the court may award a defendant attorney fees under that statute only when the "plaintiff's claim was frivolous, unreasonable, or without foundation." *Id.* at 373-74 (relying on *Christianburg Garment Co. v. EEOC*, 434 US 412, 98 S Ct 694, 54 L Ed 2d 648 (1978)). *See also Schlumberger Technologies*, 145 Or App at 21 n 9; *Robinson v. School District No. 1*, 92 Or App 627, 632, 759 P2d 1116 (1988); *Payne v. American-Strevell, Inc.*, 65 Or App 265, 268, 670 P2d 1065 (1983).

158 Or App 658> Plaintiff's claims with regard to the motion to set aside the voluntary dismissal were "frivolous, unreasonable, or without foundation" both before the trial court and on appeal. Plaintiff argued that the voluntary dismissal he previously obtained should have been set aside for mistake, inadvertence, surprise, or excusable neglect under ORCP 71 B. Essentially, plaintiff argued that the case on which he relied in making the decision to dismiss, *Tikka v. Martin*, 271 Or 287, 532 P2d 18 (1975), was not necessarily controlling. Plaintiff read that case to mean that he could refile another action against defendant after the voluntary dismissal. However, plaintiff noted that, had he conducted a more comprehensive survey of the case law, he would have discovered controlling cases holding that he would, in fact, not be able to refile against defendant.

The decision to set aside or not set aside a judgment based on mistake, inadvertence, surprise, or excusable neglect is committed to the sound discretion of the trial court, but that discretion is controlled by certain fixed legal principles. *Financial Indemnity v. Howser*, 38 Or App 369, 371-72, 590 P2d 276 (1979). For at least a century, the general rule has been that the professional mistakes, negligence, or inadvertence of an attorney do not constitute the "mistakes, inadvertence, surprise, or inexcusable neglect" necessary to set aside a judgment. *Longyear, Admx. v. Edwards*, 217 Or 314, 319-20, 342 P2d 762 (1959) (failure of attorneys to file an appearance); *Carlson v. Bankers Discount Corp. et al*, 107 Or 686, 695, 215 P 986 (1923) (failure of attorney to file an answer); *Hicklin v. McClear*, 19 Or 508, 510-11, 24 P 992 (1890) (failure of attorneys to inform themselves of content of deed); *O. R. & N. Co. v. Gates et al*, 10 Or 514, 518 (1883) (party seeking to set aside a judgment for mistake in failing to raise a particular legal argument must show that his or her failure to make that argument is *not* due to his or her own negligence or want of diligence).

In light of that rule, we find that plaintiff's claim that grounds existed to set aside the judgment under ORCP 71 B was frivolous, unreasonable, or without foundation, because it lacked any legal basis. Similarly, we find that plaintiff's argument on appeal that the trial court abused its **<158 Or App 658/659>** discretion in denying that motion was frivolous, unreasonable, or without foundation, because it, too, lacked any legal basis. We further find that an award of attorney fees in this case would not deter others from asserting good faith claims or defenses in similar cases and would deter others from asserting meritless claims and defenses.

Having established that attorney fees should be awarded in this case, however, we also find that plaintiff's objections to the amount of fees requested by defendant are well-founded. Specifically, after considering the factors listed in ORS 20.075(2), we find that the amount requested for writing the brief is unreasonable, *see* ORS 20.075(2)(a), and that some of the amounts requested by defendant's new attorneys in familiarizing themselves with the case are unreasonable. *See* ORS 20.075(2)(a) & (g). Therefore, we find that attorney fees in the amount of $12,000 are reasonable in this case. Accordingly, we adhere to our earlier order awarding attorney fees in the amount of $12,000 to defendant.

Motion of Robert C. Wyatt, Inc., to appear as *amicus curiae* denied; respondent's petition for attorney fees granted in the amount of $12,000.

Cite as 158 Or App 666 (1999) March 3, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joe M. Mann, Claimant.

LABOR READY, INC., Petitioner,
v.
JOE M. MANN, Respondent.
(WCB 96-01194; CA A100900)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 25, 1998.
Wade R. Keenon argued the cause for petitioner. On the brief was Patrick D. Gilroy.
Floyd H. Shebley argued the cause and filed the brief for respondent.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Reversed and remanded for an award of interim compensation beginning the 14th day after employer received claimant's attorney's letter of September 26, 1996.

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158 Or App 668> Employer seeks review of a unanimous en banc order of the Workers' Compensation Board (Board) holding that employer had a duty to pay interim compensation to claimant pending acceptance or denial of claimant's claim for a "new medical condition." We agree with the Board that claimant was entitled to interim compensation pending acceptance or denial of his claim. We conclude, however, that the new medical condition claim was made on September 26, 1996, by a letter from claimant's attorney, rather than on August 8, 1996, in a telephone conversation between claimant's physician and employer's insurer. Accordingly, we reverse the Board in part and remand the case for an award of interim compensation beginning the 14th day after employer received the September 26, 1996 letter.

Claimant was injured at work in January 1995, when he fell from a roof. Employer accepted a claim for rib fractures, finger dislocation, and a closed head injury. Claimant was declared medically stationary in July 1995, and the claim was closed by a determination order on September 8, 1995, with an award of temporary total disability (TTD) benefits. The determination order was affirmed in an order on reconsideration, and claimant did not seek a hearing.

After claim closure, claimant was hospitalized for a seizure. On December 20, 1995, employer denied a claim for a seizure disorder.[1] Subsequently, claimant was diagnosed with post-traumatic headaches and post-traumatic vestibular dysfunction. On August 8, 1996, claimant's attending physician, Dr. So, had a telephone conversation with employer's attorney and advised the attorney that claimant's post-traumatic headaches and post-traumatic vestibular dysfunction were related to the accepted closed head injury and that claimant would be unable to return to work pending therapy over the next 12 months. In a letter dated September 26, 1996,[2] claimant's attorney requested that employer "correct" its acceptance notice to include post-traumatic headaches and post-traumatic vestibular dysfunction. The parties **<158 Or App 668/669>** agreed to process the September 26 letter as a "new medical condition claim." Claimant also filed a claim for aggravation. Employer has neither accepted nor denied the compensability of claimant's headache and vestibular disorders and has not paid interim compensation pending its decision to accept or deny the newly diagnosed conditions. The question for our review is whether employer had a duty to begin paying interim compensation. We conclude that it did and that its obligation to do so was triggered by claimant's attorney's letter of September 26, 1996.

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[1] That claim is not a part of this proceeding.

[2] ORS 656.262(6)(d), enacted in 1995, requires the claimant to provide to the employer written communication regarding objections that "a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient."

The parties agree that claimant's claim is to be treated as a claim for a "new medical condition" under ORS 656.262(7)(a), as distinct from a claim for aggravation or an initial claim for compensation. In *Johansen v. SAIF*, 158 Or App 672, ___ P2d ___ (1999), we rejected the insurer's contention that a new medical condition claim has no existence independent of the original claim and does not give rise to a processing obligation independent of the original claim. With that background in mind, we consider employer's contention that the Board erred in holding that an employer must pay interim compensation pending its acceptance or denial of a claim for a new medical condition.

Employer asserts that, because ORS 656.262(7) does not specifically provide for the payment of TTD or interim compensation on a claim for a new medical condition, no such compensation is applicable. We reject that contention. As we held in *Johansen*, the duty to pay benefits for TTD on a new medical condition claim, although not expressly referred to in ORS 656.262(7), is encompassed within ORS 656.262(4)(a), which provides:

> "The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation."

When a claim has neither been accepted nor denied, the benefits for temporary disability that the employer must begin to **<158 Or App 669/670>** pay no later than the 14th day after notice of the claim are known as "interim compensation." *Jones v. Emanuel Hospital*, 280 Or 147, 570 P2d 70 (1977). The statutory language provides no basis to exclude the new medical condition claim from the requirement that interim compensation must be paid on a claim pending acceptance or denial.

The parties agree that claimant's attorney's letter of September 26, 1996, satisfied the requirements of ORS 656.262(7)(a) for a claim for a new medical condition. Employer's receipt of the letter triggered employer's obligation to pay interim compensation pending acceptance or denial of the claim.

We reject claimant's contention and the Board's holding that employer's telephone conversation with claimant's treating physician on August 8, 1996, constituted a claim for a new medical condition. Even assuming that the conversation constituted a claim under ORS 656.005(6), it did not satisfy the requirement for a claim for a new medical condition under ORS 656.262(7)(a) by providing notice of the new medical condition and clearly requesting acceptance of it. The September 26, 1996 letter, however, adequately did so. Claimant's entitlement to interim compensation, therefore, began no later than the 14th day after employer received claimant's attorney's letter of September 26, 1996.

Employer misreads the Board's order to hold that whether claimant is entitled to interim compensation depends on whether ORS 656.262(7)(c) requires the reopening of an original claim upon the making of a new medical condition claim. As enacted by the legislature in 1997, ORS 656.262(7)(c) 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. * * * Any objections 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.*" (Emphasis added.)

158 Or App 671> We disagree that the emphasized language of ORS 656.262(7)(c) has any bearing on whether interim compensation must be paid pending acceptance or denial of a new medical condition claim. We reiterate that employer's obligation to pay interim compensation was triggered by the filing of a claim, after closure of the original claim, for which time loss was authorized under ORS 656.262(4)(a).

Reversed and remanded for an award of interim compensation beginning the 14th day after employer received claimant's attorney's letter of September 26, 1996.

Cite as 158 Or App 672 (1999) March 3, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paul D. Johansen, Claimant.

PAUL D. JOHANSEN, Petitioner,
v.
SAIF CORPORATION and PATTERSON PLUMBING, Respondents.
(WCB 96-05209; CA A100445)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 4, 1998.
Edward J. Hill argued the cause for petitioner. With him on the brief was Carney, Buckley, Kasameyer & Hays.
David L. Runner argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.
LINDER, J.
Order of Workers' Compensation Board reversed and remanded for an award of benefits for temporary total disability.

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158 Or App 674> Claimant seeks review of an order of the Workers' Compensation Board (Board), contending that the Board erred in determining that claimant is not entitled to benefits for temporary total disability (TTD) for an accepted back condition consisting of a herniated disc. We agree with claimant that the Board erred; we therefore reverse the Board's order and remand for an award of benefits.

Claimant suffered a compensable injury to his back in November 1993, which was accepted as a nondisabling claim for acute low back strain. In June 1995, claimant's attorney wrote to SAIF, stating:

> "I note that [claimant] has been diagnosed as of March 14, 1995 with a herniated nucleus pulposus at L4-5.* * * I also note that the SAIF Notice of Claim Acceptance issued November 9, 1993 only provides for SAIF's acceptance of a condition identified as 'Acute Back Strain.' At this time [claimant] makes additional claim for his herniated nucleus pulposus at L4-5. Please respond at your earliest convenience."

SAIF accepted the herniated disc claim on August 24, 1995, expressly accepting it as a part of the 1993 acute low back strain claim, and stating, "Benefits will be paid accordingly." Subsequently, SAIF declined to pay benefits for TTD, explaining that the disc claim had been accepted as a part of the original nondisabling injury and the claim remains in nondisabling status, because the one year period for reclassifying the claim under ORS 656.277 had passed. Claimant requested a hearing, seeking benefits for TTD. The ALJ determined that claimant was entitled to benefits for time loss because, by mailing a copy of its notice of acceptance to the Workers' Compensation Division, SAIF tacitly acknowledged that the claim was disabling and that it is required to pay benefits accordingly. Further, the ALJ held that SAIF had neglected expressly to accept the claim as nondisabling, which is required to place the claim in nondisabling status.

158 Or App 675> The Board reversed the ALJ, holding that claimant was not entitled to benefits for TTD for two reasons: (1) the claim could not be reclassified from nondisabling to disabling under ORS 656.277, because more than one year had passed from the date of the injury, and (2) the documentation provided to employer was not sufficient to constitute an aggravation claim. On review, claimant asserts that when SAIF accepted the disc herniation, it accepted a claim for a "new medical condition" under ORS 656.262(7)(a), and that its acceptance requires processing of the claim pursuant to ORS 656.262, including payment of benefits for TTD.

The initial question that we address is the correct characterization and effect of claimant's attorney's letter of June 1995 making an "additional claim" for the herniated disc. The letter was received by employer after the back strain claim had been accepted as nondisabling. SAIF characterizes the letter as a claim to *reclassify* the original injury from nondisabling to disabling, pursuant to ORS 656.277. That statute provides:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation.

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

"(a) When a notice of claim denial is filed;

"(b) When the status of the claim is as described in subsection (1) or (2) of this section;

158 Or App 676> "(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon; or

"(d) When otherwise required by the director."

SAIF asserted before the Board that the June 1995 letter is a claim under ORS 656.277, that the original nondisabling injury has become disabling, and that, because the letter was received by SAIF more than one year after the date of the injury, pursuant to ORS 656.277(2), it must be treated as a claim for aggravation under ORS 656.273. Furthermore, SAIF asserts, the letter does not provide adequate documentation of a medically verified inability to work resulting from a compensable worsening and, accordingly, it does not satisfy the requirements for an aggravation claim.

The Board, sitting *en banc* with two members dissenting, determined that SAIF was correct on each of its points--*i.e.*, that the claim for reclassification, having been made more than one year after the injury, must be treated as an aggravation claim and that the documentation was insufficient to satisfy the requirements of ORS 656.273 for the filing of an aggravation claim.

The two dissenting members did not dispute the majority's view about the requirements for *reclassification* of a claim. Rather, they concluded that claimant's June 1995 letter was not an attempt to reclassify the original claim, but was instead a claim for a "new medical condition," pursuant to ORS 656.262(7)(a); therefore, the dissent reasoned, the provisions of ORS 656.277 regarding reclassification of claims were not applicable. Further, the dissent reasoned, a new medical condition claim must be processed as any other new claim, and claimant was therefore entitled to temporary disability benefits.

On review, claimant generally adopts the dissenting Board members' analysis; SAIF generally takes the same position that it took before the Board. In its view, ORS 656.262(7)(a) does nothing more than set forth the 90-day time limitation for acceptance or denial of a new medical condition claim. Central to SAIF's position is its view that, read in the context of other statutes in ORS chapter 656, a "new **<158 Or App 676/677>** medical condition" claim under ORS 656.626(7)(a) is not an independent claim that triggers an independent processing obligation under ORS 656.262 and ORS 656.268. Rather, according to SAIF, it is a claim that exists merely as part of the original injury claim. Accordingly, SAIF asserts, a new injury claim must be processed and benefits paid with reference to the original claim and pursuant to the procedural, substantive, and time limitations of ORS 656.277 and ORS 656.273.

We begin our analysis with the texts and contexts of the relevant statutes. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). The provisions relating to claim processing are interrelated. An understanding of the new medical condition claim depends on an understanding of that relationship.

ORS 656.262 describes many of the processing obligations associated with workers' compensation claims. Subsection (4)(a) provides, in part:

"The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation."

The subsection generally requires that compensation be paid no later than the 14th day after the employer has notice or knowledge of the claim. ORS 656.262 further specifies the procedures for the employer's acceptance or denial of the claim, as well as a process by which the claimant can dispute the scope of an acceptance:

> "(6)(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim.
>
> "* * * * *
>
> "(d) * * * 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 **<158 Or App 677/678>** 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."

Subsection (6)(a) thus gives an employer 90 days in which to accept or deny an initial claim. Under subsection (6)(d), a claimant who believes that a condition has been incorrectly omitted from the notice of acceptance may object to the notice in writing. The insurer then has 30 days to revise the notice or make another response. A claimant who fails to object to the notice may not later assert that a notice of acceptance is a *de facto* denial of a condition not included in the acceptance.

Subsection (7)(a) then sets forth procedures that apply after an initial claim has been accepted. It contains the first reference to claims for aggravation or new medical conditions, and describes the 90-day limitation period for acceptance or denial of those claims. A claim for a new medical condition is not separately defined in ORS 656.262 or elsewhere in Chapter 656, but the process for filing one is described in ORS 656.262(7)(a):

> "After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical conditions shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer. The insurer or self-insured employer is not required to accept each and every diagnosis or medical condition with particularity, so long as the acceptance tendered reasonably apprises the claimant **<158 Or App 678/679>** and medical providers of the nature of the compensable conditions. Notwithstanding any other provision of this chapter, the worker may initiate a new medical condition claim at any time."

The new medical condition claim must specifically request acceptance of the new medical condition. The first phrase of the subsection, "after claim acceptance," indicates generally that new medical condition claims arise after acceptance of an initial claim. Beyond that, the statute provides that a new medical condition claim may be filed at any time, "[n]otwithstanding any other provision of" ORS chapter 656. Thus, the new medical condition claim may be filed after claim acceptance and before or after closure of the initial claim, without any other time limitation. In contrast, aggravation claims are to be made "after the last award or arrangement of compensation," ORS 656.273(1), and are subject to a five-year limitation period. ORS 656.273(4)(a).

Despite the absence of express language requiring a relationship between a new medical condition claim and an initially accepted claim, we agree with SAIF that the language "after claim acceptance," as well as the context that ORS 656.262 provides to subsection (7)(a), imply that a new medical condition claim is one that relates to an initially accepted claim, and is not a claim for compensation for any new medical condition (*i.e.*, one relating to a later and different work place injury). Further, the statutory language indicates that a new medical condition claim is distinct from an

aggravation claim, which is described in ORS 656.273(1) as an "actual worsening of the compensable condition." Rather, a new medical condition is precisely that--a new condition related to the original injury, but distinct from the condition initially accepted. Thus, several distinguishing characteristics of the new medical condition are apparent from the statute. A new medical condition (1) arises after acceptance of an initial claim, (2) is related to an initial claim, and (3) involves a condition other than the condition initially accepted.

Our reading of ORS 656.262 leads us to this view of the relationship of the different types of claims: An initial **<158 Or App 679/680>** claim is filed and ultimately accepted within the time prescribed in ORS 656.262(6)(a). Benefits for temporary disability are paid no later than the 14th day after the employer receives notice or knowledge of the claim and the disability. ORS 656.262(4)(a). Once the claim is accepted, the claimant can object to the notice of acceptance and seek to have any omitted conditions included. ORS 656.262(6)(d). Also, once there is an acceptance, a claimant may file a claim for a medical condition that is related to the original claim, but is different from the condition accepted. ORS 656.262(7)(a). Finally, after the initial claim and after claim closure, a claimant may file an aggravation claim, ORS 656.273, which requires a worsening of the originally accepted condition and which expressly triggers the requirements for processing of a claim as set forth in ORS 656.262.[1]

There is no dispute in this case that claimant's attorney's letter of June 1996 described claimant's disc condition in a way that satisfies each of the three criteria that we have drawn from the statute with regard to a new medical condition and that also meets the filing requirements set forth in ORS 656.262(7)(a) for making a new medical condition claim. The ultimate issue here is whether the new medical condition claim is subject to the processing requirements of ORS 656.262(4)(a) for the payment of compensation. We conclude that it is. In the first place, a new medical condition claim, although distinct from an initial claim or an aggravation claim, is nonetheless a claim. Pursuant to ORS 656.262(4)(a), compensation for temporary disability must be paid on a claim upon medical authorization. We construe that general provision for payment of benefits to apply to all claims unless the specific provisions relating to a specific type of claim provide otherwise. Unlike the aggravation statute, ORS 656.262(7)(a), which authorizes new medical claims, does not mention what benefits flow from the claim. The statute, however, also gives no indication of an intention to exclude the new medical condition claim from the processing requirements for claims generally that are provided for in ORS **<158 Or App 680/681>** 656.262 and ORS 656.268. If, as SAIF asserts, the legislature intended that there be no independent processing obligation for a new medical condition claim, it was incumbent on the legislature to so provide.

We reject SAIF's contention that requiring the independent processing of new medical condition claims and the payment of benefits for temporary disability undermines the statutory scheme for reclassification of a nondisabling injury based on an aggravation claim. As we have said, a new medical condition claim is distinct from an aggravation claim because it involves a condition other than the one initially accepted, rather than a worsening of the accepted compensable condition. Further, although a new medical condition claim must relate to an initial claim, it is not a request for reclassification of the initial claim, which necessitates a showing that a nondisabling injury has become, or originally was, disabling. ORS 656.277. Rather, as we have said, the new medical condition claim involves a new condition not originally accepted. Accordingly, a new medical condition claim must relate to, but need not have an impact on, an original nondisabling claim. It is entitled to its own classification as disabling or nondisabling. Thus, contrary to SAIF's contention, the limitations set forth in ORS 656.277 and ORS 656.273 for reclassification of claims and aggravation claims are not affected or negated by our conclusion that a new medical condition claim must be processed as any other claim, because they are not applicable to the new condition claim.

Accordingly, we reverse the Board's order determining that no TTD benefits are due and remand the case for an award of benefits for TTD.

Order of Workers' Compensation Board reversed and remanded for an award of benefits for temporary total disability.

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[1] ORS 656.273(6) expressly provides that an aggravation claim must be processed pursuant to the provisions of ORS 656.262, and expressly includes a requirement for payment of benefits no later than the 14th day after knowledge or notice of a "medically verified inability to work resulting from a compensable worsening."

Cite as 159 Or App 12 (1999) March 10, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Peter G. Wylie, Claimant.

ACTIVE TRANSPORTATION CO. and CIGNA INSURANCE COMPANIES, Petitioners,
v.
PETER G. WYLIE, Respondent.
(WCB 96-03042; CA A99252)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 17, 1998.
Vera Langer argued the cause for petitioners on review. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Dale C. Johnson argued the cause for respondent. On the brief were Christine Jensen and Malagon, Moore & Jensen.
Before Landau, Presiding Judge, and Deits, Chief Judge,* and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

*Deits, C. J., *vice* Riggs, J., resigned.

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159 Or App 14> Employer seeks review of an order of the Workers' Compensation Board that set aside a partial denial of claimant's preexisting right knee condition. We affirm.

Claimant was working for employer when he slipped and fell, injuring his right knee. Employer accepted the injury as a disabling right knee strain. Claimant did not have any right knee symptoms before the compensable injury. Arthroscopic surgery revealed chondromalacia of the medial femoral condyle and medial tibial plateau. The attending physician, Dr. Lipp, found claimant medically stationary with no permanent impairment and the claim was closed in January 1996 with no permanent disability. Claimant, however, remained symptomatic. In March 1996, employer issued a partial denial because it believed that because it believed that a preexisting degenerative joint disease[1] in claimant's right knee was the major contributing cause of claimant's need for treatment. At the resulting hearing, the ALJ set aside the denial, holding that the compensable injury was the major contributing cause of claimant's worsened preexisting chondromalacia. On appeal, the Board affirmed. It determined that the persuasive medical evidence indicated that claimant had a combined condition under ORS 656.005(7)(a)(B). In addition, the Board agreed with the ALJ that persuasive medical evidence established that the accepted injury was the major contributing cause necessitating treatment for the combined condition.

On review, employer argues that the Board erred in treating the claim as one for a combined condition under ORS 656.005(7)(a)(B), rather than a claim for worsening of a preexisting condition. Employer asserts it denied a preexisting condition, not a combined condition. Employer relies on *Reynolds Metals v. Thrasher*, 133 Or App 30, 889 P2d 1352 (1995). There, the claimant also injured his knee and an arthroscopy revealed preexisting chondromalacia. During **<159 Or App 14/15>** the reconsideration process, the claimant sought permanent disability for his chondromalacia, even though that condition had not been accepted. After the extent of disability hearing, the employer denied the compensability of the chondromalacia. 133 Or App at 32. The Board set aside the denial, finding that the claimant's "current condition" compensable. The employer argued that it denied only the chondromalacia and not the compensability of the claimant's current condition. We agreed and remanded the case to the Board to determine whether the denied condition was compensable. 133 Or App at 33-34. Employer argues "[t]here is no difference between *Reynolds Metals* and this case." We disagree.

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[1] The administrative law judge (ALJ) concluded that chondromalacia, degenerative arthritis of the medial compartment and degenerative joint disease all referred to claimant's preexisting right knee condition and that these terms were used interchangeably by the physicians.

Here, employer denied that claimant's compensable condition was the major contributing cause of claimant's need for treatment. Instead it alleged that the preexisting chondromalacia was the major contributing cause of the need for treatment. Out of necessity, the Board had to determine the nature of the medical treatment that claimant was receiving in order to determine its major contributing cause. In reviewing the medical evidence, the Board found that claimant's treatment was for a combined condition, *i.e.*, the compensable knee strain combined with the preexisting chondromalacia. Substantial evidence in the record supports the Board's finding. The Board did not err in finding that employer's denial of claimant's medical treatment denied the compensability of claimant's combined condition.

Employer further contends that if, as we have concluded, the claim is to be treated as one for a combined condition, then the combined condition is an occupational disease and not an injury. We reject that contention. An occupational disease stems from conditions that develop gradually over time. ORS 656.802. *Mathel v. Josephine County*, 319 Or 235, 240, 875 P2d 455 (1994). By contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Id.*; *Valtinson v. SAIF*, 56 Or App 184, 188, 641 P2d 548 (1982). It is undisputed that the condition for which claimant seeks compensation became symptomatic when claimant slipped and fell. Substantial evidence supports the Board's determination that the claim should be regarded as one for an injury rather than an occupational disease. Employer does not challenge **<159 Or App 15/16>** the Board's finding that persuasive evidence established the accepted injury was the major contributing cause for treatment of the combined condition.

Affirmed.

Cite as 159 Or App 44 (1999) March 17, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth P. Bundy, Claimant.

FRED MEYER, INC., Petitioner,
v.
KENNETH P. BUNDY and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,
Respondents.
(95-07510; CA A95905)

En banc
Judicial Review from Workers' Compensation Board.
Argued and submitted April 16, 1998; resubmitted en banc October 14, 1998.
Craig A. Staples argued the cause and filed the briefs for petitioner.
Roger Ousey argued the cause for respondent Kenneth P. Bundy. With him on the brief was Bischoff, Strooband & Ousey, P. C.
No appearance for respondent Department of Consumer and Business Services.
David L. Runner filed a brief *amicus curiae* for SAIF Corporation and Timber Products Company.
Deborah L. Sather, Tracy J. White, and Krishna Balasubramani filed a brief *amicus curiae* for Northwest Natural Gas, Precision Castparts Corp., Safeco Insurance Co., and Freightliner Corporation.
Before Deits, Chief Judge, and Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim, Kistler, Judges, and Warren, Senior Judge.
EDMONDS, J.
Reversed and remanded for reconsideration.
Wollheim, J., dissenting.

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159 Or App 47> Employer seeks review of a Workers' Compensation Board (Board) order ruling that claimant is entitled to temporary disability benefits as of May 11, 1993. We review for errors of law, ORS 656.298(7) and ORS 183.482(8), and reverse.

Claimant has a compensable right wrist condition. The claim was initially closed in 1992. In May 1993, claimant filed an aggravation claim and a request for surgery, which employer denied. The denial was set aside by the Hearings Division, and employer appealed to the Board, which affirmed. That order has become final. In May 1995, claimant requested temporary disability benefits. On May 24, 1995, claimant's attending physician authorized the payment of temporary partial disability (TPD) compensation from November 1992 through April 1995. Employer acknowledged receipt of the authorization, but paid no TPD. In August 1995, employer issued a notice of closure that was subsequently affirmed on reconsideration. The order awarded TPD from April 25, 1995 to August 3, 1995, the date that claimant had become medically stationary. Claimant requested a hearing on the order on reconsideration, arguing that he was entitled to TPD beginning on May 11, 1993, the date the aggravation claim was made. The Board agreed with claimant's argument, and employer seeks review.

Employer argues that:

> "The 1995 Legislature determined, by enacting ORS 656.262(4)(g),[1] that an attending physician may not retroactively establish a claimant's entitlement to temporary disability benefits for any period unless he has authorized the disability within 14 days of such period. The Board majority erred in concluding that this provision applies **<159 Or App 47/48>** only to an employer's procedural obligation to pay temporary disability while a claim is open and does not also govern the claimant's ability to establish substantive entitlement to such benefits upon claim closure." (Internal footnote omitted).

In response to employer's argument, claimant asserts:

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[1] During the time in question, the statute was numbered ORS 656.262(4)(f). In 1997, ORS 656.262(4)(f) (1995) was renumbered to ORS 656.262(4)(g). Or Laws 1997, ch 639, section 7. We refer to it by its current number.

> "The changes made to Chapter 656 by Oregon Law 1995, Chapter 332 should not be retroactively applied to this claim. However, if the provisions of Oregon Laws 1995, Chapter 332 are applicable, the 1995 revisions to ORS 656.262 did not eliminate the distinction between procedural and substantive temporary disability. Even if the amendments did abolish the distinction, the limitation on retroactive authorization does not apply to the present case where the claimant had been seen by the attending physician for several years. The legislature intended to prohibit retroactive authorization for cases involving initial claims. In the present case, the worker had seen his attending physician to obtain ongoing treatment for the same condition for a period of five years."

The meaning of ORS 656.262(4)(g) is the focal point of the parties' arguments. It provides:

> "Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

ORS 656.262(4)(g) was enacted by the Legislature in 1995. Senate Bill 369; Or Laws 1995, ch 332. ORS 656.262(4)(g) was enacted while this claim was in litigation. Therefore, the amendment applies. *Jensen v. Conagra, Inc.*, 152 Or App 449, 954 P2d 822 (1998);[2] *Volk v. America West* <159 Or App 48/49> *Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

The remaining issue in this case is whether ORS 656.262(4)(g) applies to only procedural obligations to pay temporary disability while a claim is open, or whether it also applies to the substantive entitlement to benefits at claim closure. The Board ruled that ORS 656.262(4)(g) is only an additional requirement for the authorization of procedural temporary disability compensation during an open claim. It reasoned that, because the terms in the statute are in the present tense and thereby address the contemporaneous payment of compensation while the claim is in open status, it follows that the statute does not apply to awards of temporary disability made at the time of closure. The Board noted that a claimant's entitlement to temporary disability benefits under ORS 656.210 and ORS 656.212 was not amended in 1995 in any way that was material to the meaning of ORS 656.262(4)(g) and that neither ORS 656.210 nor ORS 656.212 contains any language that limits a worker's substantive entitlement to temporary disability to only those periods for which there has been contemporaneous authorization by the attending physician. Based on that reasoning, the Board concluded that ORS 656.262(4)(g)'s restriction on the authorization of temporary disability benefits was inapplicable to claimant's claim for substantive temporary disability benefits.

The pertinent statutes are reasonably susceptible to the construction given to them by the Board. However, that conclusion does not end the inquiry. In interpreting a statute, our task is to discern the intent of the legislature. ORS 174.020. The text of the statutory provision itself is the starting point for interpretation because it is the best evidence of the legislature's intent. We also consider the context of the statutory provision at issue, which includes other provisions of the same statute and other related statutes as well as rules of construction of the statutory text that bear directly on how to read the text. If the legislature's intent is clear from such an inquiry, there is no need to go further. It is with those rules in mind that we examine ORS 656.262(4)(g) to determine whether the Board's interpretation is the only reasonable construction of the meaning of ORS 656.262(4)(g).

159 Or App 50> On its face, ORS 656.262(4)(g) is not limited to benefits that are due and payable during the time that the claim is open. The first sentence in the statute tells the reader when temporary disability compensation is not due and payable; the second sentence in the statute restricts the retroactive authorization of temporary disability compensation to a time period of not more than 14 days. The fact that the verbs in the statute are in the present tense does not negate the possibility that the statute also applies to awards of time loss[3] made at claim closure. Whether time loss is awarded

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[2] We held in *Jensen* that ORS 656.262(4)(g) applied retroactively to existing claims and that the statute, "creates a limit on the amount of retroactive benefits to which claimant is entitled, *i.e.*, two weeks. That limit, defining as it does a claimant's rights, is substantive." 152 Or App at 453.

[3] For purposes of this opinion and in the legislative history, "time loss" is a term encompassed in the term "temporary disability" compensation or TPD.

while a claim is open or at closure will always be an act that occurs contemporaneously to the overall processing of the claim. Moreover, the reference to ORS 656.268 in both sentences is a reference to a statute that addresses the process of claim closure. Finally, the fact that ORS 652.210 and ORS 656.212, statutes regarding the substantive entitlement to temporary disability, remain unchanged is not determinative of the issue. The legislature could well have intended that the requirements in those statutes remain the same, while intending to superimpose upon them a limitation on the retroactive award of such benefits. We conclude, based on the above examination, that the intent of the legislature is not clear from the text and the context of ORS 656.262(4)(g).[4] In light of its language, the legislature could have intended that the 14 day restriction on TPD apply to both procedural and substantive time loss.

As a result of the purpose of the legislature not being clearly discernable from the text and context of ORS 656.262(4)(g), we consider the legislative history underlying the statute. Our review of the legislative history discloses that the changes in ORS 656.268 were: "Intended to preclude a closure order from making a substantive award of time loss benefits for any period of time during which procedurally the **<159 Or App 50/51>** time loss benefits were lawfully suspended or withheld or terminated." Tape recording, Joint Meeting of Senate Committee on Labor and Government Operations and House Committee on Labor, February 1, 1995, Tape 19A.

In addition, the following exchange took place at a legislative committee meeting on Senate Bill 369:

> "[Representative Kevin Mannix addressing Senator Randy Leonard]: You were surprised, and I think even shocked, that it could be possible under the act that a physician could do retroactive time loss. Senator, it happens. And, we've been required to respond to it. And, we've been penalized for not paying it -- periods of time during which the time loss might have been monitored, the worker's medical condition might have been reported on, but it wasn't. We end up getting a retroactive authorization for -- I have seen two years of time loss, I have seen more.
>
> "[Senator]: Retroactive?
>
> "[Jerry Keene]: Doctor says, I'm going back two years to authorize time loss even though I haven't seen you. This says you can go back fourteen days.
>
> "[Senator]: Just give me the example.
>
> "[Keene]: Worker files a claim based on a recent visit to a physician and says, I had this problem a couple of years ago * * * and doctor says, in my opinion, this person couldn't work as of a year ago based on that condition or injury.
>
> "[Senator]: Evaluation today?
>
> "[Keene cont.]: And I'm authorizing retroactive time loss. This section says you can't do that more than fourteen days back. If somebody is that badly off that they need time loss, they should see a physician to get authorization for the time loss. And it's reasonable for someone who has been hurt--they went home for a few days, they were in bed and weren't getting [doctor's care]--to take a few days to get to the doctor so that's why the fourteen days * * *.
>
> "[Senator]: Actually that was clarified to me after I asked the questions. Well, that kind of a situation--yes, you could get hurt and then later go to the doctor and it could be a few days. So that actually made sense."
>
> "* * * * *

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[4] Apparently, the dissent would hold that when the legislature used ORS 656.268 in the language of ORS 656.262(4)(g), it really meant to say "ORS 656.268(3)(d)." Presumably, the legislature knows how to specifically incorporate a subsection of a statute into another statute. If the legislature had intended ORS 656.262(4)(g) to incorporate only ORS 656.268(3)(d), it would have said so.

159 Or App 52> "[Keene cont.]: This does not affect the time limit for making a claim. It just affects how far back a doctor can give you time loss.

"[Senator]: For time loss. I see. Okay." Tape recording, Joint Meeting of Senate Committee on Labor and Government Operations and House Committee on Labor, February 17, 1995, Tape 48B.

Later, Mannix stated in support of the bill:

"* * * [T]here have been ludicrous situations where the worker doesn't go to a physician for a couple of months on the initial claim, and the physician said, oh yeah, I'll retroactively authorize time loss all the way back. This makes it clear that you can only do that up to 14 days. If someone really needed to be off work, they should be seeing an attending physician." Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A.

As indicated previously, ORS 656.268 addresses the process of claim closure, including the procedure for determining awards of permanent disability, termination of temporary total disability and the events that result in termination of benefits. ORS 656.268(3) was amended as part of the 1995 changes. It now provides, in pertinent part:

"(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"* * * * *

"(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."

As a result of the above amendment, temporary disability benefits are terminated not only when the worker returns to work or is released to return to work, but upon the occurrence of the events enumerated in ORS 656.262(4).[5] The incorporation of ORS 656.262(4) events into ORS 656.268(3) as **<159 Or App 52/53>** events that act to terminate the obligation to pay temporary disability is a manifestation of the legislature's intention that closure orders be precluded from awarding time loss benefits for any period of time during which there is no procedural entitlement. Thus, the legislative history when read with the text and context of the applicable statutes makes it clear that the reference in ORS 656.262(4)(g) to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days, whether the claim was open or was pending closure.

The dissent contends that our decision in this case should be controlled by our holdings in *Shaw v. Rebholz*, 152 Or App 328, 954 P2d 190 (1998) and *Santos v. Caryall Transport*, 152 Or App 322, 954 P2d 187 (1998). In *Shaw*, the issue was whether the employer could be ordered to make temporary partial disability payments beyond the date that the claimant became medically stationary. The claimant contended the Board was precluded from determining that he was not entitled to benefits after that date because, in an earlier proceeding, it had concluded that the employer had improperly terminated claimant's benefits. The Board concluded that ORS 656.268 as amended by the 1995 legislature continues

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[5] ORS 656.268(3) provides in its entirety:

"(3) 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."

to address a claimant's entitlement to benefits awarded at closure, and it ruled that claimant was not entitled to benefits beyond the date that he was disabled. On review, we summarily rejected the claimant's argument that the distinction between "substantive" and "procedural" entitlement had been legislatively overruled by the 1995 legislature by citing to *Santos*.

In *Santos*, the issue was again whether an employer could be ordered to pay temporary partial disability payments beyond the date that the claimant was medically stationary. He argued that he was entitled to temporary disability benefits because amended ORS 656.268 no longer provides for the termination of benefits at the time that a claimant becomes medically stationary. He also argued that ORS 656.262(4)(g) could not be applied to him retroactively. **<159 Or App 53/54>** We did not decide the latter argument. Rather, we cited a number of cases that had been decided since the 1995 amendments, and we concluded that claimant's arguments were controlled by our holding in *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992). In that case, we held that the claimant's substantive entitlement to temporary benefits ended on the medically stationary date, and that the Board lacked the authority to order an employer to pay benefits beyond that date.

Our holdings in *Santos* and *Shaw* are not controlling.[6] Whether a claimant is entitled to benefits after becoming medically stationary is not the issue. As to the award of retroactive time loss, the legislature's intent is clear that ORS 656.262(4)(g) provides a limitation on all awards of temporary disability under ORS 656.268. Under ORS 656.262(4)(g), the passage of time acts by operation of law to restrict the retroactive authorization of time loss. Consequently, claimant's physician was without authority to authorize temporary disability retroactively for a period of more than 14 days. We conclude that the Board erred when it ruled that claimant was entitled to substantive temporary disability from May 11, 1993, through April 24, 1995.[7]

Reversed and remanded for reconsideration.

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[6] The legislature makes law by enacting new statutes. When it acts, our task is to interpret what the legislature has done by giving effect to the legislature's intention. It is beyond our authority to create law based on a statute that is different from what the legislature intended. ORS 174.010; ORS 174.020. Although the dissent believes that essential to the determinations in the decisions in *Santos* and *Shaw* was a distinction between substantive and procedural entitlement to temporary disability benefits, neither opinion expressly considers the legislature's intent in that regard. Moreover, our prior case law is of no consequence when the legislature acts anew, as it did here. Because of the 1995 amendment to ORS 656.262, the rule of *stare decisis* is inapplicable. The dissent's analysis based on those precedents necessarily fails in the light of the ambiguity of ORS 656.262(4)(g), which requires us to discern the legislature's intent from the legislative history underlying the amendment.

[7] Employer paid temporary loss benefits after April 24, 1995.

WOLLHEIM, J., dissenting.

The majority opinion ignores case law that existed before the adoption of ORS 656.262(4)(g) and case law after its adoption. The majority opinion acknowledges that the Board's interpretation of the relevant statutes is reasonable. **<159 Or App 54/55>** The Board's statutory interpretation is not only reasonable, it is also the correct interpretation. For this reason, I dissent.

The primary question is whether ORS 656.262(4)(g) abolished the distinction between procedural and substantive temporary disability benefits. Although it has its basis in the statutes, the "substantive/procedural" terminology is not found in ORS chapter 656. The distinction has been described in case law. *Lebanon Plywood v. Seiber*, 113 Or App 651, 833 P2d 1367 (1992). The substantive entitlement for temporary total disability benefits is set forth in ORS 656.210, which provides that "[w]hen the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages * * *." Temporary total disability benefits are awarded to replace lost wages due to a compensable temporary disability. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 295, 702 P2d 403 (1985). Substantive time loss is the temporary total disability award, which the injured worker is entitled to receive at the time of closure by virtue of proof that the injured worker experienced a period of temporary total disability before claim closure. *SAIF v. Taylor*, 126 Or App 658, 660-61, 870 P2d 245 (1994).

An injured worker's procedural entitlement to time loss is the temporary total disability benefits that the employer or insurer is obligated to *pay* on an open claim by virtue of the procedures of claim processing before the injured worker becomes medically stationary. The ability to obtain payment of benefits for temporary total disability while the claim is open is dependent on the satisfaction of a number of conditions, most of which are set forth in ORS 656.262. In *Atchley v. GTE Metal Erectors*, 149 Or App 581, 585, 945 P2d 557, *rev den* 326 Or 133 (1997), we said:

> "[T]he general distinction between a substantive and procedural entitlement is that a substantive benefit is one that is made explicit and unconditional by statute, while a procedural benefit is conditional, arising solely from the vagaries of claim processing."

A substantive award of temporary disability at the time of closure may exceed or be less than the procedural time loss payments to which an injured worker was entitled **<159 Or App 55/56>** during the time when the claim was open. That is, an employer or insurer may be required to pay additional time loss payments or may be entitled to an offset for any overpaid time loss benefits. To this date, this court has not construed the condition for payment of benefits for time loss, as set forth in ORS 656.262, as creating limitations on the award of benefits to which the injured worker is entitled under ORS 656.210 at the time of closure. This court has not held that a failure to carry out the procedures necessary to obtain payment of temporary total disability benefits while a claim is open bars an award for the entire period of disability at the time of closure.

I agree with the majority that we must first examine the text and context of ORS 656.262(4)(g). *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993); *Deluxe Cabinet Works v. Messmer*, 140 Or App 548, 553, 915 P2d 1053, *rev den* 324 Or 305 (1996). I disagree with the majority in that I believe the text and context of ORS 656.262(4)(g) support the Board's decision. Because I believe the legislative intent is clear from the text and context of ORS 656.262(4)(g), I do not consider the legislative history. A review of the relevant portions of ORS 656.262 follows.

ORS 656.262(4)(a) describes generally how benefits to time loss are paid, with the first installment due "no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." The initial payment of time loss benefits is due upon authorization by the attending physician. With the exception of ORS 656.262(4)(f), which relates to the compensability of medical services, each subsequent subparagraph of subsection (4) relates to a circumstance affecting the payment of temporary total disability benefits while the claim is open. ORS 656.262(4)(d) is the first subsection to speak about "verification" of disability, as distinct from authorization of benefits. Temporary total disability is not due and payable during the period of time where the attending physician's verification of an inability to work has been requested but not received, unless the claimant has been unable to receive treatment for reasons outside the claimant's control.[1] In *Taylor*, this court **<159 Or App 56/57>** interpreted that subsection, then numbered (4)(b), and held that the requirement for verification of disability is a procedural limitation on the payment of benefits when the claim is open and does not alter the claimant's substantive entitlement to an award of benefits for the entire period of disability. We said that even if medical verification is not provided, as required under subsection (4)(d), and benefits are not due and payable while the claim is open, the benefits to which the claimant is substantively entitled become due and payable at the time of closure:

> "As we held in *Sandoval v. Crystal Pine*, 118 Or App 640, 848 P2d 1224, *rev den* 317 Or 272 (1993), the suspension of benefits pursuant to ORS 656.262(4)(b) due to the absence of medical verification of an inability to work does not terminate the claimant's substantive entitlement to benefits. The benefits to which the claimant is substantively entitled become due and payable when the claim is closed." 126 Or App at 661.

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[1] Explicit in ORS 656.262(4)(d) is the provision that the claimant may be entitled to temporary disability benefits that were not due and payable if the claimant can later establish that no treatment was received for reasons beyond the claimant's control. Implicit in this subsection is that the claimant can later establish that fact when the claim is closed and the claimant is awarded temporary disability benefits. Under the majority's analysis, a claimant would not be entitled to later receive time loss benefits even if it was established that the reason the claimant was unable to receive treatment was outside the claimant's control. Thus, the majority's analysis renders subsection (4)(d) nugatory.

Under ORS 656.262(4)(e), the claimant's failure to attend an appointment with the attending physician may allow the employer or insurer to suspend the payment of benefits. ORS 656.262(4)(f) does not concern the payment of time loss benefits.

Under ORS 656.262(4)(g), the disputed provision, no benefits are "due and payable pursuant to ORS 656.268" after the attending physician ceases to authorize them or for any period not authorized. Further, no authorization by a physician "under ORS 656.268" may retroactively authorize more than 14 days of benefits. From this brief summary, it can be readily determined that ORS 656.262(4) is primarily about the payment of benefits on an open claim, *i.e.*, when payment must be made, when payment is not due and payable, and when payment may be unilaterally suspended. As the statute's repeated reference to the subject bears out, the **<159 Or App 57/58>** legislature considers authorization of benefits and verification of disability to be prerequisites to obtaining payment of temporary disability benefits on an open claim. Authorization of benefits and verification of disability, or the lack thereof, are determinative under ORS 656.262(4) for the purpose of obtaining temporary disability benefits while a claim is open and before being processed for claim closure. I presume that the legislature's use of "not due and payable" and the unilateral suspension of benefits is intentional and, further, that the legislature used different language because it intended different meanings. *Dale v. Electrical Board*, 109 Or App 613, 616, 820 P2d 868 (1991).

The process for *awarding* benefits on a claim at the time of closure, as distinct from paying benefits for time loss before closure, is set forth in ORS 656.268. *See Fazzolari v. United Beer Distributors*, 91 Or App 592, 595, 757 P2d 857, *adhered to* 93 Or App 103, 761 P2d 6, *rev den* 307 Or 236 (1988) (ORS 656.268 *only* deals with the processing of claims). For example, ORS 656.268(5)(a) provides that when the department receives the medical and vocational reports concerning an accepted disabling injury claim, the claim shall be examined and "further compensation, including permanent disability award, if any, [be] determined * * *." This implies that an injured worker may be entitled to further compensation for temporary disability beyond what was due and payable while the claim was open. ORS 656.268(13) provides:

> "Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including * * * crediting temporary disability payments against current or future permanent or temporary disability awards or payments and requiring the payment of temporary disability payments which were payable but not paid."

Under ORS 656.268(15)(a), an employer or insurer may offset any compensation payable to the worker to recover an overpayment from a claim with the same employer or insurer. Each of the described subsections sets forth how an award of compensation, either an additional or lesser amount, must be made in the closure order.

159 Or App 59> ORS 656.268(3) describes the circumstances under which temporary disability benefits continue unless a specified event first occurs. ORS 656.268(3) provides:

> "Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "(a) The worker returns to regular or modified employment;
>
> "(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;
>
> "(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or
>
> "(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter."

Subsection (3)(d) refers to ORS 656.262(4) and authorizes a discontinuance of temporary disability benefits based on "[a]ny other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) * * *." However, subsection (3)(d) does not include the language from ORS 656.262(4)(g) of "not due and payable."

This court previously interpreted ORS 656.262(4)(g) not to require an employer to pay the claimant more than two years of retroactive temporary disability benefits while the claim was open. *Jensen v. Conagra, Inc.*, 152 Or App 449, 954 P2d 822 (1998). We rejected the claimant's arguments that ORS 656.262(4)(g) did not apply to open claims. *Id.* at 452-53.

ORS 656.262(4)(g), in turn, refers to ORS 656.268 in stating its requirement for authorization of time loss. The question here is whether the requirement for authorization of time loss applies for purposes of the award of benefits at the time of closure and, if so, whether the limitation on retroactive authorization also applies to the award of benefits.

159 Or App 60> ORS 656.262(4)(g) twice refers to ORS 656.268:

> "Temporary disability compensation is not due and payable *pursuant to ORS 656.268* after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized * * *. No authorization * * * by the attending physician *under* ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance." (Emphasis added.)

The Board interpreted the references in ORS 656.262(4)(g) to ORS 656.268 to relate only to ORS 656.268(3)(d), rather than to ORS 656.268 in its entirety. It held that the limitations expressed in ORS 656.262(4)(g) are additional procedural restrictions on the payment of time loss benefits while a claim is open, but that they do not restrict an award of benefits at the time of closure. The majority disagrees.

The placement of ORS 656.262(4)(g) among the subparagraphs, which we have previously held relate only to procedural limitations on the payment of time loss benefits, supports claimant's and the Board's interpretation. To adopt the majority's interpretation would be a significant departure from prior statutes and our case law interpreting them. *Taylor; Sandoval; Fazzolari; Vip's Restaurant v. Krause*, 89 Or App 214, 748 P2d 164, *adhered to* 91 Or App 472, 756 P2d 47, *rev den* 306 Or 414 (1988). I am unwilling to assume that the legislature intended such a departure without very clear statutory language that it did so.

The language of ORS 656.268(4)(g) does not support the majority's interpretation. The first sentence of subsection (4)(g) is expressly limited to temporary disability benefits not due and payable "pursuant to ORS 656.268." That statute is only a procedural statute. *Fazzolari*, 91 Or App at 595. Because temporary disability benefits suspended under the first sentence of subsection (4)(g) are, by definition, being paid *pursuant to* ORS 656.268, this sentence is limited to the procedural entitlement to temporary disability benefits. The second sentence of subsection (4)(g) expressly refers to an attending physician's authorization of temporary disability benefits "under ORS 656.268." The explicit reference to ORS 656.268 limits the application of this sentence of (4)(g) to the **<159 Or App 60/61>** procedural entitlement of temporary benefits while the claim is open. I cannot ignore the legislature's explicit reference to ORS 656.268 by omitting what the legislature inserted. ORS 174.010. Thus, like the first sentence, the second sentence of subsection (4)(g) is also limited to the procedural entitlement to temporary disability benefits.

The distinction between procedural and substantive benefits applies *only* to temporary disability benefits. There are no procedural permanent disability benefits, no procedural medical benefits, nor procedural vocational assistance benefits. Under the majority's reading of ORS 656.262(4)(g), the distinction between procedural and substantive temporary disability benefits no longer exists. No employer or insurer would ever be required to pay temporary benefits more than 14 days before the attending physician's authorization.

To reach this result, the majority overrules our recent decisions in both *Shaw v. Rebholtz*, 152 Or App 328, 954 P2d 190 (1998), and *Santos v. Carryall Transport*, 152 Or App 322, 954 P2d 187 (1998). Essential to the decision in *Shaw*, this court had to determine whether the legislature abolished the distinction between procedural and substantive benefits:

> "Claimant insists that the distinction between his entitlement to temporary disability benefits during the pendency of the open claim and his entitlement to the benefits at closure relies on a distinction between 'substantive' and 'procedural' entitlements that has been legislatively overruled. We have rejected that argument." 152 Or App at 333.

In *Santos*, the issue was whether the employer was required to pay time loss benefits after the claimant was medically stationary. 152 Or App 322. The claimant argued that the amendments to ORS 656.268(3) were the only authority for the unilateral termination of time loss benefits and that because being medically stationary was not one of the statutory grounds for the unilateral termination of time loss benefits, the claimant was entitled to such benefits until the claim was closed. *Id.* at 325. We rejected the claimant's arguments and held that the distinction between procedural **<159 Or App 61/62>** and substantive entitlements was not changed by either the 1990 or the 1995 amendments to ORS chapter 656. *Id.* at 327.

The majority is correct that the holdings in *Santos* and *Shaw* are not directly on point. 159 Or App at 54. The majority and I disagree about the effect of this decision on *Santos* and *Shaw*. Essential to both decisions was that this court held the distinction between substantive and procedural entitlement to temporary disability benefits was not abolished by either the 1990 nor the 1995 amendments to ORS chapter 656. However, the majority here holds that the 1995 amendments to ORS 656.262(4)(g) abolished the distinction between substantive and procedural temporary disability benefits.

In summary, both sentences of ORS 656.262(4)(g) explicitly refer to ORS 656.268, the statute for processing and closing a claim. ORS 656.268 refers to procedural, not substantive, temporary disability benefits. Accordingly, I would hold that ORS 656.262(4)(g) applies only to procedural entitlement to temporary disability benefits. Here, the award of temporary disability benefits was substantive, and the Board's order was proper.

There is another reason to affirm the Board: *stare decisis*. The rule of *stare decisis* was discussed by the Supreme Court in *Multnomah County v. Sliker*, 10 Or 65, 66 (1881):

> "[T]he rule is said to be almost universal that in construing statutes and the constitution, [the courts] adhere to the doctrine of *stare decisis* [even though a different conclusion might be reached] * * * unless error is plainly shown to exist * * *."

This language was recently relied on by Judge Edmonds, dissenting in *Newell v. Weston*, 156 Or App 371, 383, 965 P2d 1039 (1998). The majority opinion ignores the rule of *stare decisis* and overrules two recent decisions by this court. I do not believe the majority has established that plain error exists. I fear this decision undermines an important policy of the appellate courts of this state: to afford certainty to the administration of justice. The changing of the goal posts by judicial fiat can only lead to uncertainty in the law and **<159 Or App 62/63>** encourage litigants to question settled law. Nor can it be said that the law concerning ORS 656.262(4)(g) is even settled. Perhaps another litigant will raise this issue again, and this court, perhaps with different members, will reexamine this statute and decide that Santos and Shaw were correctly decided. Such changes do not promote the rule of stare decisis, nor do they promote the administration of justice.

Because I would affirm the Board's decision, it would be necessary to reach employer's second assignment of error. Employer asserted that the Board erred in determining that claimant was disabled during the period in question. I would hold that the Board's determination is supported by substantial evidence.

I dissent.

De Muniz and Armstrong, JJ., join in this dissent.

Cite as 159 Or App 229 (1999) March 17, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of George D. Koskela, Claimant.

GEORGE D. KOSKELA, Petitioner,
v.
WILLAMETTE INDUSTRIES, INC., Respondent.
(WCB 95-08576; CA A97325)

En Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted December 2, 1997; resubmitted en banc February 3, 1999.

David W. Hittle argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander, McCann & Smith.

David L. Johnstone argued the cause for respondent. With him on the brief were E. Kimbark MacColl, Jr. and VavRosky, MacColl, Olson, Busch & Pfeifer, P.C.

David L. Runner, Appellate Counsel, filed a brief *amici curiae* for SAIF Corporation and South Hills Health Care Center.

Before Deits, Chief Judge, and Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim and Kistler, Judges, and Warren, Senior Judge.

LINDER, J.

Affirmed.

Edmonds, J., concurring.

De Muniz, J., dissenting.

Wollheim, J., dissenting.

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159 Or App 231> Claimant seeks review of a Workers' Compensation Board (board) order awarding him permanent partial disability (PPD) rather than permanent total disability (PTD). The petition for review raises only one issue: whether the administrative procedures for determining the extent of the permanent disability--in particular, the process for reconsideration and hearing--satisfy the requirements of the federal Due Process Clause. We hold that they do and affirm.

Claimant, who is approximately 60 years old, has a history of extensive temporomandibular joint (TMJ) difficulty, which involves episodic jaw pain and discomfort. He has been medically treated for that condition since at least 1982, and his treatment has included several surgeries. He suffered compensable injuries to his jaw twice, first in 1986 and again in 1989. In 1994, his treating physician declared him to be medically stationary, triggering the claim closure process. As part of that process, three other physicians independently examined claimant to assess the extent of his disability. Their examination included review of a videotape of defendant engaging in certain activities (*e.g.*, mowing his lawn, driving his pickup, chopping wood, and fishing). Based on the videotape and their physical examinations, those physicians concluded that claimant could perform at least sedentary work. Claimant's treating physician also viewed the videotape and agreed that claimant likely could perform certain activities, but he was unsure whether claimant could do so on a daily basis.

The Department of Consumer and Business Services (DCBS) reviewed the medical reports and issued a determination order finding claimant to be medically stationary and awarding him PPD. Claimant requested reconsideration by DCBS, seeking a determination that his disability is total, rather than partial. In requesting reconsideration, claimant did not dispute the impairment findings used to rate the extent of the disability. As a result, DCBS submitted the claim to the Appellate Review Unit (unit) for reconsideration, rather than appoint a medical arbiter to review the rating. In its order on reconsideration, the unit reviewed the physicians' reports and agreed that claimant was only partially **<159 Or App 231/232>** disabled. However, the unit modified the determination by increasing the PPD disability rating pursuant to a temporary rule.[1]

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[1] In rating permanent disability cases, temporary rules may be adopted in individual cases where the director finds "that the worker's impairment is not adequately addressed in the disability standards." OAR 436-035-0500. In this instance, on reconsideration, the disability rating changed from 14 to 29 percent unscheduled PPD, with an impairment value of 8, to account for the disabling effects of claimant's episodic jaw pain.

Claimant sought administrative review, invoking his right to a hearing before an administrative law judge (ALJ). Before the hearing, claimant indicated he was prepared to offer his testimony, the testimony of his family physician, and the testimony of a vocational expert "to substantiate claimant's case" and to show "in a convincing manner that claimant is permanently and totally disabled." Claimant could have submitted that evidence by affidavit at the prior level of administrative review (reconsideration), but he made no effort to do so. Because that evidence had not been submitted at reconsideration, the ALJ ruled it inadmissible under ORS 656.283(7).[2] At the hearing, claimant's counsel again asked to present the testimony and asserted a right under the Due Process Clause to do so. The ALJ rejected claimant's due process argument and limited her consideration to the evidence presented at reconsideration and submitted at hearing for the ALJ's consideration. On the basis of that evidence, the ALJ found that claimant was not entitled to PTD. Claimant appealed to the board, asserting that under the Due Process Clause, the proffered testimony should have been considered. The board rejected the constitutional claim and, on *de novo* review of the record, affirmed the ALJ's order.

159 Or App 233> At the outset, it is helpful to clarify the precise legal challenge that claimant makes. Claimant asks us to declare invalid the 1995 amendment to ORS 656.283(7), which bars the admission of evidence at an ALJ hearing that was not presented at the prior stage of administrative review (reconsideration). *Rogue Valley Medical Center v. McClearen*, 152 Or App 239, 952 P2d 1048, *rev den* 327 Or 123 (1998). With that change, determining the extent of an accepted disability under Oregon's workers' compensation statutes is based primarily on the presentation of written medical reports and other documentary and written submissions. There is no point during the administrative closure process at which a claimant, as a matter of right, can orally submit his or her own testimony and the direct testimony of other witnesses.

Claimant wages a facial attack on that administrative structure, contending that it denies a claimant seeking PTD due process of law under the Fourteenth Amendment to the United States Constitution. Claimant briefly canvasses the closure, reconsideration, and hearing procedures, taking issue with the fact that, in light of the amendment to ORS 656.283(7), there is no point during the administrative process at which a claimant receives a trial-type hearing as part of determining the extent of a compensable disability. Claimant concludes by arguing:

> "On balance the claimant's protected interest in permanent total disability benefits entitles him to a trial-type hearing. Such procedural safeguards were not provided at either the reconsideration or hearing level. Consequently, claimant was denied the procedural due process guarantees of the Fourteenth Amendment."

Thus, although claimant's immediate challenge is directed to the limitation on evidence newly imposed by ORS 656.283(7) at the ALJ level, the rationale for the challenge is the failure to provide a trial-type hearing at any point in the PTD determination.

Employer responds that the reconsideration and hearing processes, notwithstanding their evidentiary limitations, adequately protect claimant's due process interests. Employer points out that claimant had the opportunity to present his full case by written reports and affidavits at the **<159 Or App 233/234>** reconsideration level, but that claimant chose not to avail himself fully of that opportunity. Additionally, employer observes that, at the hearing before the ALJ, claimant could have cross-examined the author of any written vocational report, pursuant to ORS 656.287(1), as long as that report was presented at reconsideration. All of those procedures provide, in employer's view, meaningful opportunities to contest the relevant issues and adequately ensure the reliability of the decision.

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[2] ORS 656.283(7) was amended pursuant to Senate Bill 369, Oregon Laws 1995, chapter 332, section 34, effective June 7, 1995, to provide:

> "Except as otherwise provided in this section * * * the Administrative Law Judge is not bound by common law or statutory rules of evidence[.] * * * Evaluation of the worker's disability by the Administrative Law Judge shall be as of the date of issuance of the reconsideration order pursuant to ORS 656.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. * * * *Evidence on an issue regarding a * * * determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing*[.]" (Emphasis added.)

The Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property, without due process of law." The question of what process constitutionally is due involves three inquiries: (1) whether the person invoking the due process claim has a constitutionally protected interest in the particular benefit at stake; (2) whether deprivation of that interest involves government action; and (3) whether the procedures used or available are constitutionally adequate. *See generally Carr v. SAIF*, 65 Or App 110, 117-18, 670 P2d 1037 (1983), *rev dismissed* 297 Or 83 (1984).

The parties do not dispute that an injured worker has a protected property interest in a determination of PTD status and that denial of that status involves government action. *See id.* at 118.[3] The only issue, then, is the constitutional adequacy of the administrative procedures provided by state law to determine a claimant's entitlement to PTD benefits. As the United States Supreme Court has observed: "[O]nce it is determined that the Due Process Clause applies, 'the question remains what process is due.'" *Cleveland Bd. of Educ. v. Loudermill*, 470 US 532, 541, 105 S Ct 1487, 84 L Ed 2d 494 (1985) (quoting *Morrissey v. Brewer*, 408 US 471, 481, 92 S Ct 2593, 33 L Ed 2d 484 (1972)).

Fundamentally, the question posed by a procedural due process challenge is whether, given what is at stake, the **<159 Or App 234/235>** procedures used to reach that decision provide sufficient confidence in the decision made. *Mathews v. Eldridge*, 424 US 319, 335, 96 S Ct 893, 47 L Ed 2d 18 (1976), frames the analysis as a three-part balancing test:

> "[F]irst, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."

The private interest at stake here is claimant's entitlement to PTD versus PPD benefits. PTD benefits serve as replacement wages for a worker who, due to the disabling effects of a compensable injury, permanently cannot return to regular and suitable gainful employment. ORS 656.206(2)(a). We recognized in *Carr* that temporary total disability (TTD) benefits, which compensate an injured worker on a temporary basis for the same inability to work, represent a significant interest to a claimant. Specifically, "[d]eprivation of compensation, even for a relatively brief period of time, and the resulting possible loss of ability to acquire essential goods and services, may threaten the health and safety of the worker and his dependents." *Carr*, 65 Or App at 121. PTD benefits, if awarded, replace TTD benefits when a claimant becomes medically stationary. In a case such as this, however, the difference is not between full wage replacement and no wage replacement at all, but rather is between full wage replacement and partial wage replacement, both on a permanent basis. Even so, a claimant's interest in PTD benefits is significant and a deprivation can have important consequences, as in *Carr*.[4]

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[3] Our conclusions in *Carr* that workers' compensation benefits involve government action and protected property interests have been drawn into doubt by the United States Supreme Court's recent opinion in *American Mfrs. Mut. Ins. Co. v. Sullivan*, ___ US ___, ___ S Ct ___, ___ L Ed 2d ___ (March 3, 1999). However, the parties in this case have assumed *Carr's* correctness and have not raised and briefed those points. Given our rejection of the due process challenge, we need not consider *Sullivan's* implications for this case.

[4] Judge De Muniz's dissent characterizes the potential loss of PTD benefits as "much more grievous" and deserving of "significantly more procedural protection" than the loss of TTD benefits in *Carr*. 159 Or App at 254 (De Muniz, J., dissenting) With all respect, at some point the argument invites judicial hair-splitting, because the gradations in seriousness cannot be assessed or quantified meaningfully. Comparing the inquiry here to that in *Carr* illustrates the problem. In *Carr*, the claimant risked the loss of an *entire* source of income, albeit for a finite time. Moreover, the TTD decision, once final, was not subject to modification. Here, in contrast, the issue is whether claimant's accepted disabling condition merits full wage replacement or partial wage replacement; that determination, while nominally "permanent," is subject to later modification under some circumstances. *See, e.g.*, ORS 656.273 (worsened conditions); 656.278(5) (authority of insurer to reopen claim to provide greater benefits); ORS 656.206(5) (PTD awards must be reviewed every two years). Because the issue here is a reduced benefit, not a complete denial of one, we are unwilling to consider claimant's interest as "much more grievous" than the claimant's interest in *Carr*. *See* Henry J. Friendly, *Some Kind of Hearing*, 123 U Pa L Rev 1267, 1298 (1975) (suggesting that suspension of benefits should be treated as more serious than their reduction). But neither do we attempt to quantify the unquantifiable by measuring in pounds and ounces how much each of these related interests weighs on the due process scale.

159 Or App 236> Analysis of the second factor from *Mathews*--the risk of an erroneous deprivation and the value of added process--requires first an assessment of the existing claim closure, reconsideration, and hearing processes by which a PTD determination is made, together with the nature of the administrative decision to be made. "Claim closure" is the process for determining the amount of benefits to be awarded on a permanent basis for a claim already accepted as disabling. As a general proposition, claim closure occurs when either the worker or the employer asserts that the worker's disabling condition has become medically stationary, ORS 656.268, unless the worker is actively engaged in a vocational training program. ORS 656.268(1)(c).

Typically, when PTD status is at issue, a worker will not have returned to work and will not have been released by a physician to return to work. In those circumstances, the insurer must ask DCBS to close the claim, rather than do so itself. *See* ORS 656.268(2)(a) and (4)(a). Copies of all medical reports and reports of vocational rehabilitation agencies or counselors must be provided to DCBS. ORS 656.268(2)(b). Medical reports must be in writing and may include, among other items: the history of the injury or disease; other pertinent medical history; date of examination; findings on examination; impairment of physical or mental function; restrictions on activities (such as lifting, bending, twisting, sitting, standing, and repetitive use); likelihood of permanent impairment and opinion as to whether the condition is likely to change; and the reason for the opinion. OAR 438-007-0005(2). Vocational reports may be submitted by consultants employed by governmental agencies or insurers and by private vocational consultants. ORS 656.287(1). Those reports **<159 Or App 236/237>** may address job opportunities, a claimant's fitness to perform certain jobs, prevailing wage levels, and other information relating to employability and loss of earning capacity. *Id.*

Upon receipt of relevant medical and vocational information, DCBS within 10 working days must issue a "determination order" finding the extent of the worker's permanent disability as a result of the accepted disabling injury. ORS 656.268(5)(a); OAR 436-030-0030(4). DCBS may postpone issuance of the determination order for up to 60 days if it concludes that additional medical or other information is necessary. ORS 656.268(5)(a).

Either party, or both parties, may request reconsideration of the determination order. ORS 656.268(5)(b) and (6)(a). Reconsideration is performed by a "special evaluation appellate unit" within DCBS, which has 18 days to complete the reconsideration. ORS 656.268(6)(d). If the unit requires additional time, it may delay a decision for 60 days to obtain the needed information. *Id.*

The record on reconsideration consists of documents included at the time of claim closure, together with any additional documents submitted for the reconsideration proceeding. *See generally* OAR 436-030-0155. On reconsideration, the parties are entitled to correct and to clarify information in the record that is erroneous and may submit medical evidence that should have been, but was not, submitted by the treating physician. ORS 656.268(6)(a); OAR 436-030-0115(1). Although the director of DCBS may order otherwise, a reconsideration proceeding typically "does not include personal appearances by any of the parties to the claim or their representatives." OAR 436-030-0115(2). However, the parties are entitled to submit documents encompassing factual information and written arguments relevant to the worker's status at the time of claim closure. OAR 436-030-0115(3). All interested parties must receive copies of those documents. OAR 436-030-0135(1). Information submitted for reconsideration also "may include, but is not limited to, responses to the documentation and written arguments of the opposing **<159 Or App 237/238>** party, written statements and sworn affidavits of the parties." OAR 436-030-0115(3). Thus, reconsideration is performed primarily, if not completely, on the basis of a documentary record, together with written arguments of the parties.

If either party is dissatisfied with the order on reconsideration, it may request a hearing under ORS 656.283 before an ALJ. ORS 656.268(6)(g). Except for issues arising out of the reconsideration order, the only issues that may be considered at the hearing are those that were raised and preserved at reconsideration before DCBS. ORS 656.268(8). In certain respects, the hearing is informal. For example, the ALJ is not bound either by common law or statutory rules of evidence, or by technical or formal rules of procedure. ORS 656.283(7). Instead, the hearing is conducted "in any manner that will achieve substantial justice." *Id.* After the 1995 amendment to ORS 656.283(7), however, the scope of admissible evidence in a hearing to close a claim is limited significantly by one criterion: the evidence must have been submitted at the reconsideration level. If that criterion is satisfied, either party at the hearing may subpoena the other party's medical and vocational experts and cross-examine them. If, without good

cause, an expert refuses to make himself or herself available for cross-examination, that expert's report is generally excluded from evidence. OAR 438-007-0005(3).[5]

159 Or App 239> The substantive decision to be made--whether a claimant is PTD--must be considered against that procedural backdrop. "Permanent total disability" is statutorily defined as "the loss * * * of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). "Suitable occupation" refers to those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience and the realistic ability to perform the job duties, with or without rehabilitation. OAR 436-030-0055(1)(b). Before a worker will be determined to be PTD, the worker must prove that the disability is permanent and total. OAR 436-030-0055(3). If a worker retains "some residual functional capacity and is not medically permanently and totally disabled," the worker must prove, using "competent written vocational" evidence, that he or she is unable regularly to perform work at a gainful and suitable occupation. OAR 436-030-0055(4). If the worker has not made reasonable work search efforts, the worker's burden includes showing the futility of seeking work, again with "competent written vocational" evidence. *Id.* "Competent written vocational" evidence consists only of the opinions of persons fully certified by the State of Oregon to render vocational services and does not include opinions by claimants, physicians, or others not certified. *Id.*

Several important observations follow from the description of the procedures relevant to PTD status and the standards for the decision to be made. First, PTD status is an intensively medical and vocational issue, one that lends itself particularly to expert opinion. Second, a claimant seeking to establish PTD status is entitled to present information from every relevant source at the reconsideration stage. That is, the claimant may present the relevant opinions of experts, lay witnesses, and himself or herself on issues relating to the extent of impairment and loss of earning capacity. Third, and finally, the procedural limitations that attend to the PTD decision are ones of form, not substance. The procedures call for exploration of the medical and vocational issues through **<159 Or App 239/240>** reports, affidavits, written argument, and written response. Unlike a traditional trial-type hearing, the process does not involve live testimony of witnesses, with the exception of cross-examination of vocational and medical experts on the substance of their reports and opinions.

Claimant's primary contention is directed to the second *Mathews* factor--*i.e.*, the contention that the reconsideration process produces a substantial risk of erroneous PTD determinations. Claimant argues that the "[l]imitations on what can be considered for reconsideration virtually preclude claimant from thoroughly presenting, rebutting or cross-examining evidence." In this particular case, claimant declined the opportunity to present his case fully at reconsideration, where he could have offered his own testimony, as well as that of his family physician and a private vocational counselor, in the form of affidavits, reports, or other documentary evidence. As we understand claimant's position, his point is that, as a matter of due process, he is entitled to forgo presenting written evidence at the reconsideration level and then insist on presenting it for the first time through live witnesses before the ALJ.

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[5] Judge Wollheim's dissent takes issue with our observations about the parties' ability under the rule to cross-examine experts on the contents of medical reports, concluding that the rule is invalid because it conflicts with the evidentiary limitations of ORS 656.283(7). 159 Or App at 258 (Wollheim, J., dissenting). Our analysis does not depend on that feature of the hearing process because, as we later explain, the issues lend themselves well to proofs and counter proofs through expert reports and written documentation. Nevertheless, we describe the terms of the rule because, as it stands, the rule is part of the available process. As a general proposition, an administrative rule remains an effective statement of existing practice or policy until it is either judicially invalidated or repealed through proper APA procedures. *See Burke v. Children's Services Division*, 288 Or 533, 538, 607 P2d 141 (1980). We are not prepared sua sponte to declare it invalid, where, as here, the rule's validity has not been drawn into question. Nor are do we share the dissent's confidence that the rule is fatally inconsistent with the statute. Legislative authorization for the rule at least arguably resides in ORS 656.283(7), which authorizes the ALJ to conduct the hearing "in any manner that will achieve substantial justice." We have previously concluded that permitting cross-examination of vocational experts at hearing, as the legislature expressly has done, is not inconsistent with the statute's evidentiary limitations. *McClearen*, 152 Or App at 244-45. The same, at least arguably, may be said of a rule permitting cross-examination of medical experts at hearing, if the expert's report was submitted at reconsideration.

As a threshold matter, we fail to understand how the limitations on the form of evidentiary submissions at reconsideration can excuse presentation of that evidence at that level. Even assuming that claimant is correct and that he is entitled, at the hearing, to produce witnesses for direct and cross-examination before the decisionmaker, that does not mean that he may deliberately bypass written presentation of the evidence to DCBS for consideration in making its administrative decision on reconsideration. The statutory scheme reflects a legislative policy of requiring the parties to come forward with all issues that they intend to raise and all information that bears on those issues for meaningful consideration by the agency charged with the administrative decision. *See* ORS 656.268(7)(g) (no post-reconsideration evidence of medical impairment is admissible); ORS 656.268(8) (no hearing shall be held on any issue not raised and preserved before DCBS at reconsideration); ORS 656.283(7) (issues regarding claim closure cannot be raised at hearing if not raised before DCBS; evidence on issues not presented at **<159 Or App 240/241>** reconsideration is not admissible at hearing).[6] Claimant cites no authority, nor are we aware of any, for the proposition that a person seeking an administrative benefit is entitled to withhold information bearing on the claim at lower administrative levels on the theory that later levels of administrative review either will or must involve live testimony rather than written submissions.

In all events, we disagree that due process requires more procedural protection than the administrative structure for reconsideration and hearing provides.[7] As the United States Supreme Court has emphasized, due process "'is not a technical conception with a fixed content unrelated to time, place and circumstances,'" *Cafeteria Workers v. McElroy*, 367 US 886, 895, 81 S Ct 1743, 6 L Ed 2d 1230 (1961) (quoting *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 US 123, 162, 163, 71 S Ct 624, 95 L Ed 817 (1951) (Frankfurter, J., concurring)), but instead flexibly "calls for such procedural protections as the particular situation demands." *Morrissey v. Brewer*, 408 US 471, 481, 92 S Ct 2593, 33 L Ed 2d 484 (1972). Claimant's challenge flows from his predicate assertion that the procedures afforded him do not provide a "trial type hearing on adjudicative facts." The argument assumes, incorrectly, that adjudicative procedures are an all-or-nothing proposition--that is, that they either are a mere **<159 Or App 241/242>** opportunity to comment and be heard or are full-blown evidentiary contests, complete with direct and cross-examination.

To the contrary, as the United States Supreme Court has cautioned, in reiterating what it referred to as the "wise admonishment" of Justice Frankfurter, "differences in the origin and function of administrative agencies 'preclude wholesale transplantation of the rules of procedure, trial and review which have evolved from the history and experience of courts.'" *Mathews*, 424 US at 348 (quoting *FCC v. Pottsville Broadcasting Co.*, 309 US 134, 143, 60 S Ct 437, 84 L Ed 2d 656 (1940)). The fact that the transplant is not wholesale does not mean that the process is not adjudicative or adversarial. Nor does it mean that the decision is necessarily less reliable: "The judicial model of an evidentiary hearing is neither a required, nor even the most effective, method of decisionmaking in all circumstances." *Id.* In short, due process is not a one-size-fits-all principle that requires full-blown, trial-type procedures wherever anything more than a mere opportunity for comment is needed.

Although the procedures for reconsideration and ALJ review do not model judicial trial procedures, they offer a meaningful process for adjudicating facts contested by the parties. It is worth emphasizing that at the point of closure, the compensability of the injury and the fact that it is permanently disabling have been established. Only the *extent* of the disability remains to be determined. DCBS's initial extent determination is made on the basis of medical and vocational reports that, by the

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[6] Testimony in support of the 1995 amendments to ORS 656.283(7) is replete with expressions of concern that "the issues be raised at the lowest possible level for resolution" and that the record under review "be the same at all levels of appeal." *See, e.g.*, Tape Recording, House Committee on Labor, SB 369, March 8, 1995, Tape 48A (testimony of Virlena Crosely, Workers Compensation Division Administrator). *See generally In re Ray*, 48 Van Natta 325 (1996) (reciting at greater length the legislative history of the 1995 amendment to ORS 656.283(7)).

[7] We reach the constitutional question, as did the ALJ and the board, notwithstanding claimant's failure to present the proffered testimony in documentary form at reconsideration. We do so because the 1995 amendments to ORS 656.283(7) took effect after claimant requested reconsideration and the reconsideration process had commenced. At hearing, claimant challenged whether the requirement of presenting the evidence at reconsideration could be applied retroactively to him. He abandoned that challenge at the board level and has abandoned it before this court. Thus, that issue is not before us. But because the statute was not in effect when reconsideration commenced, we do not resolve this case on the narrow ground that claimant was obligated to present the proffered evidence in documentary form at reconsideration before he may, through live testimony or otherwise, insist on presenting it at the ALJ hearing.

time of claim closure, frequently will have involved many years' worth of professional assessment and treatment of a claimant's work-related injury and accompanying disability.[8] At the reconsideration phase, a claimant has the opportunity to take issue with the initial determination order and to submit written documentation, both medical and vocational, to correct and clarify the record. The employer may do the same. A claimant also can present lay testimony by affidavit. Both parties are entitled **<159 Or App 242/243>** to present written argument and to respond in writing to each other's submissions. Thus, the process is adversarial and permits affirmative proofs, counter proofs, and written argumentation. As the board accurately observed:

> "Taken together, the reconsideration procedures enabled claimant to present in writing the lay, medical and vocational evidence supporting his entitlement to PTD benefits. That is, claimant had the opportunity to present essentially the same evidence on reconsideration [that] he sought to present at hearing, albeit in somewhat different form. The substance of any lay and/or expert witnesses' testimonies could have been presented by sworn affidavits at the time of reconsideration. In this regard, we reject claimant's argument that oral testimony was necessary for him to establish he was willing to seek employment and made reasonable efforts to obtain such employment; that evidence could have been presented by affidavit at reconsideration. The evidentiary limitation in *amended* ORS 656.283(7) is on the form and timing, not the substance, of the evidence relevant to the PTD issue."

In *Mathews*, the Supreme Court was confronted with a nearly identical constitutional challenge in the context of social security disability benefits, where the benefit decision turned on whether a potential recipient was "disabled." 424 US at 343-45. The court rejected the idea that medical evidence and evaluation could be meaningfully presented and tested only through direct and cross-examination of live witnesses, concluding instead that written submissions by physicians were at least as reliable, if not more so.[9] The Court **<159 Or App 243/244>** then acknowledged that the question of disability does not always turn solely on a medical diagnosis, but also frequently depends on nonmedical factors such as age, education, work experience, and the ability to find gainful employment. On the issue of employability, the Court similarly concluded that the live examination of witnesses would not meaningfully aid the decision:

> "The value of an evidentiary hearing, or even a limited oral presentation, to an accurate presentation of those factors to the decisionmaker does not appear substantial. Similarly, resolution of the inquiry as to the types of employment opportunities that exist in the national economy for a physically impaired worker with a particular set of skills would not necessarily be advanced by an evidentiary hearing. * * * The statistical information relevant to this judgment is more amenable to written than to oral presentation." *Id.* at 344 n 28 (citation omitted).

The same conclusion follows here. The "essence" of due process is to provide a person in jeopardy of serious loss notice of the case against him and an opportunity to meet it. *Id.* at 348. Those values are amply served by the procedures in place for claim closure. Claimant's due process challenge is to *the form* of claimant's evidence (*i.e.*, affidavit versus oral examination), not whether the decision-maker has access to whatever relevant information the claimant wants to provide. Because the disability

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[8] By way of illustration, the record before DCBS in this case contained nearly 13 years' worth of medical, vocational, and psychiatric assessments relating to claimant's disability.

[9] The Court concluded:

> "[T]he decision whether to discontinue disability benefits will turn, in most cases, upon 'routine, standard, and unbiased medical reports by physician specialists,' *Richardson v. Perales*, [402 US 389, 404, 91 S Ct 1420, 28 L Ed 2d 842 (1971)], concerning a subject whom they have personally examined. In *Richardson* the Court recognized the 'reliability and probative worth of written medical reports,' emphasizing that while there may be 'professional disagreement with the medical conclusions' the 'specter of questionable credibility and veracity is not present.' [*Id.* at 405]. To be sure, credibility and veracity may be a factor in the ultimate disability assessment in some cases. But procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions. The potential value of an evidentiary hearing, or even oral presentation to the decisionmaker, is substantially less in this context than in [the context of welfare benefits]." *Mathews*, 424 US at 343-45 (footnote omitted).

determination is directly driven by medical and vocational inquiries, an evidentiary hearing with live witnesses would not significantly advance the decision, nor does its absence subject the reliability of the outcome to an unacceptable risk of error.

Claimant argues that *Mathews* is distinguishable, because there the Court was addressing the procedures followed for an initial determination of social security benefits in the context of a scheme that gave the applicant a later, more trial-type adversarial hearing. We acknowledge that difference and that the decision in *Mathews* therefore is not controlling, despite its close parallels to this case. But we cannot so readily discount the substance of the Court's discussion, which emphasized the minimal and incremental benefit of live witness testimony given the nature of the decision to **<159 Or App 244/245>** be made. As the Supreme Court has cautioned, "[p]rocess is not an end in itself." *Olim v. Wakinekona*, 461 US 238, 250, 103 S Ct 1741, 75 L Ed 2d 813 (1983). If the process sought does not meaningfully advance the decision to be made--and we conclude that it would not here--the Due Process Clause does not require it.[10]

Claimant finally contends that issues peculiar to some PTD determinations, such as employability and willingness to work, place a claimant's credibility uniquely at issue and require, as a constitutional matter, that a claimant be permitted to testify. But *see Califano v. Yamasaki*, 442 US 682, 696-97, 99 S Ct 2545, 61 L Ed 2d 176 (1979).[11] The dissenting opinions agree, urging that in so-called "odd lot" cases, a claimant may remain capable of performing some kind of work, but be totally disabled because a combination of medical and nonmedical factors forecloses him or her from gainful employment in a realistic job market. The dissenting opinions urge that in those cases, a claimant's credibility **<159 Or App 245/246>** takes on a special role. As a result, nothing less than live witnesses, complete with direct and cross-examination, will do. See 159 Or App at 252-53 (De Muniz, J., dissenting); 159 Or App at 259 (Wollheim, J., dissenting).

In responding to that contention, the starting point is to recognize that so-called "odd lot" cases are a subclass of the universe of cases decided pursuant to the procedures that claimant challenges. Claimant here has made a *facial* challenge to the statute. The crux of that challenge is that a trial-type hearing is required at the hearing level for *all* closure determinations, including those involving only medical issues.[12] Unlike the inquiry in, for example, an unemployment case,[13] credibility is not directly

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[10] To illustrate the importance of cross-examination, Judge De Muniz's dissent urges that claimant should have been permitted to cross-examine witnesses about the surveillance video of defendant's activities. 159 Or App at 255 (De Muniz, J., dissenting). Due process procedures are shaped by the risk of error in the general case to be decided, not by the value of the procedure in a particular case. *See post* 159 at 248. Even so, the dissent's point is not well taken. Claimant did not share the dissent's concerns about the videotape and never suggested by his offer of proof that he wanted or needed to examine anyone about it. Nor does claimant make that argument on appeal.

[11] Even if credibility were more of a key to the PTD determination, *Califano* suggests that the procedures provided would be ample. In *Califano*, the Supreme Court distinguished between the procedures required for recoupment of social security payments under different provisions of the social security statutes. Where the recoupment is based on matters of computation (even the recipient's own errors), the court held that no oral hearing whatsoever is required, because credibility is involved only rarely in such cases. *Califano*, 442 US at 696. On the other hand, where a recipient sought to have the recoupment waived on the basis of the recipient's lack of "fault," the Court determined that credibility is central to the waiver, and therefore some form of oral hearing is required. *Id.* at 697. Significantly, the oral hearing the Supreme Court envisioned was a far cry from the trial-type procedures that claimant demands here. The Court approved administrative rules providing only for "'a short personal conference with an impartial employee of the Social Security Administration.'" *Id.* (quoting from the respondent's brief). *See generally Gray Panthers v. Schweiker*, 716 F2d 23 (DC Cir 1983) (where credibility was central to administrative decision, oral hearing but not full trial procedures required). Here, a claimant is present and receives an oral hearing before the decisionmaker.

[12] Indeed, that is the only challenge that claimant preserved. At the hearing, claimant sought to introduce testimony of direct witnesses (himself, his personal physician, and a vocational counselor) "to substantiate claimant's case." He made no offer of proof as to what those witnesses would say. Claimant's request to call witnesses and present direct testimony at hearing was adequate to preserve the issue of whether he is entitled, as a legal matter, to a "trial-type" hearing. *See State v. Olmstead*, 310 Or 455, 461, 800 P2d 277 (1990) (where entire class of evidence is excluded as a legal matter, party need not make a specific offer of proof to preserve argument of legal entitlement to have decision based on such evidence). But if the argument is that particular *substance or content* of the testimony requires the evidentiary limitations of the statute to give way, no such claim has been presented or preserved in this case.

[13] *See, e.g., Thompson v. Employment Division*, 82 Or App 75, 727 P2d 158 (1986) (remanding to administrative factfinder for credibility findings on availability for work because the issue was central to the decision to be made).

at stake in PTD determinations generally, at least not in any demonstrable way. Before claim closure, the worker already has been determined to be compensably disabled. The question at closure is only the extent of that compensable disability. Thus, a PTD determination hinges largely on medical evidence concerning the degree of disability and on vocational evidence regarding the nature of the work that can be performed, given medical limitations. That fact is underscored by the aggressive program of vocational rehabilitation offered to injured workers, using professionals specially certified by DCBS, and involving vocational evaluation, physical capabilities evaluation, general vocational assistance, and help in directly obtaining employment and training. *See generally* ORS 656.340.

Even as to "odd lot" cases, however, neither claimant nor the dissenting opinions satisfactorily demonstrate the **<159 Or App 246/247>** extent to which the PTD determination turns on a claimant's credibility or that the credibility assessment cannot be made reliably without live testimony. To make the case for the importance of live testimony, the argument must be not only that credibility is central to the decision, but that a *demeanor-based* credibility determination is essential to the integrity of the determination. To be sure, personal demeanor provides insight into credibility, especially when the dispute involves competing versions of historical facts, such as two witnesses' differing memories of an event.[14] That reality leads appellate courts generally to defer on credibility matters to factfinders who had the opportunity to "see and hear" the witness testify. *E.g., Good Samaritan Hospital v. Employment Div.*, 104 Or App 241, 243, 799 P2d 1141 (1990). However, as Judge Richardson aptly observed some years back, demeanor is only one of many considerations that may, in a given case, bear on the weight to give to a witness's statements; meaningful credibility assessments can be and often are made on the basis of written evidence alone:

> "[I]f the conclusion is that [a decision-maker] cannot make credibility findings because he has not observed the witnesses testifying, the simple answer is that credibility (more properly weight) is determinable from a number of factors other than witness demeanor. The credibility, i.e., weight, that attaches to testimony can be determined in terms of the inherent probability, or improbability of the testimony, the possible internal inconsistencies, the fact it is or is not corroborated, that it is contradicted by other testimony or evidence and finally that human experience demonstrates it is logically incredible."

Lewis and Clark College v. Bureau of Labor, 43 Or App 245, 256, 602 P2d 1161 (1979), *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part) (responding **<159 Or App 247/248>** to the suggestion of Buttler, J., concurring, that commissioner improperly assessed credibility of witnesses in her review of record of contested case hearing).

Although claimant and the dissenting opinions assert that credibility--presumably, demeanor-based credibility--is "crucial" to assessing a claimant's willingness to work, saying that does not make it so. An examination of the relevant inquiry, as outlined by the statutes and administrative rules, does not bear out the point. That examination suggests, instead, that the reports, experience, and opinions of medical and vocational professionals are far more fundamental to determining the extent of a compensable disability. Nor does case law in the area reflect that demeanor-based credibility assessments are the centerpiece of most PTD determinations. Few cases suggest that the PTD determination typically turns on credibility generally. *No* case yet has been cited, and we have not found one, where the claimant's *demeanor* was noted as an important factor to the PTD determination. Were demeanor assessments as crucial to the overall PTD determination as claimant and the dissents suggest, the many years of litigation in this area would reveal as much. The reported cases suggest just the

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[14] Where credibility is concerned, the value of demeanor evidence may be overrated. Some empirical studies suggest that the observation of demeanor diminishes rather than enhances the accuracy of credibility judgments. *See generally* Olin Wellborn, *Demeanor*, 76 Cornell L Rev 1075 (1991). For present purposes, we do not need to take sides in that debate. It should be enough to observe that classic credibility contests are those in which two individuals relate competing accounts of an historical event and there is no record of the event except their memories.

opposite, however.[15] In all events, the cases do not demonstrate that demeanor-based credibility assessments are important in the "generality of cases," which is the due process standard that must be satisfied. *Mathews*, 424 US at 344 ("procedural due process rules are shaped by the risk of error inherent in the **<159 Or App 248/249>** truthfinding process as applied to the generality of cases, not the rare exceptions").

Nevertheless, one of the dissenting opinions urges, with eloquence and empassioned conviction, that injured workers simply must have the opportunity at some point to "look into the face of an impartial adjudicator and tell their stories." 159 Or App at 262 (Wollheim, J., dissenting). The dissent offers no particular clarification of the substance of what is to be related or any precise explanation of why a live recounting is so important. Without that, the argument reduces to one urging process for the sake of process, not for the sake of reducing the risk of error. Lost in the dissent's overview of more than eight decades of changes in the workers' compensation system is an acknowledgment that the inquiry in a PTD determination is a narrow one. Fault is no longer at issue in compensating injured workers. For that matter, even compensability and disability are settled at the point of closing and rating an accepted claim. Only the *extent* of disability remains to be determined. In an odd-lot case, a claimant may be able to relate facts relevant to whether the claimant has engaged in a search for suitable work or, if not, why that search would be futile. It is not obvious, however, why facts of that nature cannot be communicated effectively though affidavits and written documentation. Nor does the dissent supply the answer. The dissent's plea for "simple justice" through the "telling of one's story" is appealing for its poetic imagery. But it treats process as "an end in itself," when due process analysis requires more. *See Olim*, 461 US at 250.

Finally, concerning the third *Mathews* factor--the burden imposed on the government by additional process--we examine the government's interest in the fair and efficient administration of the workers' compensation scheme, which we have recognized as significant. *Carr*, 65 Or App at 123. Claimant argues that because he is entitled to some form of evidentiary hearing before an ALJ, his ability to testify orally and to cross-examine witnesses generally as a matter of right would "not substantially increase either the administrative burden or fiscal impact on the government." Even if the costs of allowing claimant to present live witnesses would be minimal, we are not convinced that the added procedural benefit **<159 Or App 249/250>** is required, given our conclusion that an oral presentation of direct testimony, or a general right of cross-examination, is not of substantially greater value than proof and counter-proof through written reports and affidavits.[16] More to the point, we do

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[15] Of the large number of reported PTD cases, an occasional one may turn on the injured worker's willingness to seek suitable work. *E.g., Sinclair v. Champion International Corp.*, 117 Or App 515, 844 P2d 933 (1992); *Janish v. Lane Co. S-D #45*, 106 Or App 218, 806 P2d 1164 (1991); *SAIF v. Beswick*, 104 Or App 494, 802 P2d 82 (1990); *SAIF v. Orr*, 101 Or App 612, 792 P2d 454 (1990); *Gornick v. SAIF*, 92 Or App 303, 758 P2d 401 (1988). But the reported cases do not suggest that a demeanor-based assessment of a claimant's credibility has often or generally been needed. To the contrary, judging from our reported decisions of the last several years, of the few cases in which willingness to work was even a central issue, the determination generally was based on objective information as to a claimant's age, physical limitations, education level, and the nature of the job market *E.g., Gornick*, 92 Or App at 308. Similarly, vocational, medical, and psychiatric evidence is often determinative, even when the issue turns on a claimant's motivation and attitude. *E.g., Sinclair*, 117 Or App at 517-18. Cases in which a claimant's credibility and veracity are the be all and end all of the issue appear to be rare at best; indeed, neither claimant nor the dissents cite a single case in which a claimant's credibility was determinative.

[16] It is worth noting, again, that the statutes and rules currently permit parties to cross-examine experts who have submitted written medical and vocational reports. Beyond that, as to a general right of cross-examination, Judge Friendly's observations are apt:

> "[O]ne must query [the relative value of cross-examination] to the thousands of hearings on welfare, social security benefits, housing, prison discipline, education, and the like which are now held every month--not to speak of hearings on recondite scientific or economic subjects. In many such cases the main effect of cross-examination is delay--an argument not really answered, as any trial judge will confirm, by the easy suggestion that the hearing officer can curtail cross-examination. Lawyers, including those who have gone on the bench, have a vivid recall of the few instances where they destroyed a dishonest witness on cross-examination and forget those where their cross-examination confused an honest one or was ineffective or worse--not to speak of the many cases when they had the good judgment to say 'No questions.'" Friendly, U Pa L Rev at 1284-85.

not agree that the costs are as *de minimis* as claimant suggests. Evidentiary hearings with the personal appearance of witnesses involve scheduling burdens and consume time and resources. The exact financial and efficiency costs may be difficult to estimate. However, "experience with the constitutionalizing of government procedures suggests that the ultimate additional cost in terms of money and administrative burden would not be insubstantial." *Mathews*, 424 US at 347. Likewise, here, the burden would be real.

Judge De Muniz's dissenting opinion asserts that there has never been a significant complaint about the cost of providing trial-type hearings at the ALJ level, but it cites nothing to support that statement. 159 Or App at 256 (De Muniz, J., dissenting). Actually, neither the dissent nor we know what the budget impact of those hearings has been or the extent to which they have been a fiscal concern. But more important, the cost to be considered is not just cost at the ALJ level. The legislature restricted evidence at the ALJ level to ensure that issues be raised before DCBS to give it the full benefit of the parties' proofs and arguments as part of its administrative review. *See* n 6, infra. The governmental goals thus include administrative accuracy, efficiency, and **<159 Or App 250/251>** reduced cost, by removing the incentive to seek an ALJ hearing for the opportunity to try the case anew on the basis of new and different evidence. The goal also is to preserve the integrity of the process, both by ensuring a more complete process at the DCBS level and by not treating ALJ "review" as an opportunity to blindside parties with changed proofs. Those interests are both legitimate and weighty, even if they cannot be measured easily in dollar amounts and do not reflect concerns about dollars alone.

Given the procedures in place--which allow for wide-ranging documentary proofs, counter proofs, and other responsive submissions--and balancing the low value of oral testimony and the burden of trial-type administrative process, we conclude that due process principles do not entitle a claimant to present evidence through in-hearing testimony rather than through written reports and sworn affidavits. Claimant received constitutionally adequate procedural protections under the existing scheme.

Affirmed.

EDMONDS, J., concurring.

Under the applicable statutory and administrative rule scheme, the only issues on which demeanor-based credibility could be crucial in the determination of permanent total disability are the issues under ORS 656.206(3).[1] As to those issues, claimants have the opportunity to meet the burden imposed by the statute by submitting affidavits, including their own, on reconsideration. Under ORS 656.283(7), the administrative law judge "may conduct the hearing in any manner that will achieve substantial justice." It is evident that the legislature contemplated a process whereby any inadequacy, such as an insufficient record arising from the restriction of evidence through affidavits to determine credibility, could be addressed at the hearing level. In that light, ORS 656.283(7) meets general due process standards. That **<159 Or App 251/252>** does not mean, in my view, that in a particular case, a claimant could not make a successful "as applied" challenge if denied the ability to meaningfully controvert an adverse credibility finding after the reconsideration process and if denied the protection of the statute.

For this reason, I concur with the majority opinion.

Warren, S. J., joins in this concurrence.

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[1] ORS 656.206(3) provides:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

DE MUNIZ, J., dissenting.

In 1995, the Oregon Legislature amended ORS 656.283(7) to limit the evidence that may be considered by an administrative law judge (ALJ) to evidence submitted at the reconsideration phase of the claim determination process. Claimant contends that the amended statute denies due process to workers seeking permanent total disability (PTD) benefits because there is no meaningful opportunity, at any point in the claim determination process, to present live testimony or rebuttal evidence or to cross-examine witnesses. The majority appears to hold that due process is satisfied because, in its view, PTD determinations turn mainly on medical facts and that written submissions generally used at the reconsideration phase are a meaningful way to present such facts. However, workers seeking PTD benefits also have the additional burden of proving a willingness to work and that they have made a reasonable attempt to obtain employment. The burden of proof that a worker must carry on those issues will, for the most part, turn on an evaluation of the worker's credibility. In the context of the workers' compensation system, that kind of evaluation should be made only in an adjudicative hearing. Additionally, claimant here was denied PTD benefits, in part, on the basis of medical reports that relied on a surveillance video. In my view, written submissions by a worker at the reconsideration phase are not a meaningful or sufficient way for a worker to dispute or neutralize the effect of that kind of nonmedical hearsay. I dissent because denying injured workers an adjudicative hearing in which an ALJ evaluates all of the evidence, including the worker's demeanor and veracity, violates the worker's right to due process of law.

159 Or App 253> The commonly stated fundamental requirements of due process are notice and the opportunity to be heard at a meaningful time and in a meaningful manner. *State ex rel Juv. Dept. v. Geist*, 310 Or 176, 189-90, 796 P2d 1193 (1990). The question here is whether evidence, generally in written form at the reconsideration phase, allows a worker to be heard in a meaningful manner. As the majority correctly states, the framework for answering that question is the balancing test formulated in *Mathews v. Eldridge*, 424 US 319, 335, 96 S Ct 893, 47 L Ed 2d 18 (1976). On one side of the balance is the value of the private interest at stake and the probability that additional safeguards will reduce the risk of an erroneous deprivation of that interest. On the other side is the government's interest and the cost of the additional safeguards proposed. *See State ex rel Schrunk v. Metz*, 125 Or App 405, 416-18, 867 P2d 503 (1993) (deciding that prompt post-seizure hearings are needed to protect an ownership interest in commercial property).

The majority's application of the *Mathews* test is technically correct. The majority finds that claimant has a protected interest in the determination of PTD benefits but that the existing procedures restricting evidence to that considered at the reconsideration phase present a low risk that claimant will be deprived erroneously of that interest. It then balances those factors against the government's interest in the fair administration of disability benefits and the cost of additional safeguards, which it characterizes as not insubstantial. My disagreement with the majority centers on the weight given to the first two factors. In my view, the majority undervalues both the significance of claimant's interest in PTD benefits and the risk of an erroneous deprivation under the existing procedures.

As to the first factor, the majority determines that the value of claimant's interest in PTD benefits is similar to a protected interest in uninterrupted temporary total disability (TTD) benefits because a denial of either would threaten claimants' health and safety. *Carr v. SAIF*, 65 Or App 110, 120, 124, 670 P2d 1037 (1983), *rev dismissed* 297 Or 83 **<159 Or App 253/254>** (1984).[1] The majority then suggests that the significance of claimant's interest is diminished by his receipt of a PPD award. I disagree with the majority's reasoning. The significance of claimant's interest in a PTD determination is unrelated to his PPD award[2] and, instead, should be measured by the extent to which a failure of due process would condemn claimant to suffer grievous loss. *Goldberg v. Kelly*, 397 US 254, 262-63, 90 S Ct 1011, 25 L Ed 2d 287 (1970).

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[1] Recently, the Supreme Court issued a decision that calls into question the validity of *Carr*. *American Mfrs. Mut. Ins. Co. v. Sullivan*, US , S Ct , L Ed 2d (March 3, 1999). However, the parties here did not dispute that the denial of permanent total disability benefits involves government action. Or App at (slip opinion at 5).

[2] In *Mathews*, the Supreme Court commented that "[e]ligibility for disability benefits is * * * *wholly unrelated* to the worker's income or support from many other sources such as * * * *workmen's compensation awards*[.]" 424 US at 340 (emphasis added).

The comparative value of the interests at stake in *Carr* and here are apparent in the plain meaning of the words temporary and permanent. A temporary interruption of TTD benefits for a worker who may return to work, although significant, is less important than a permanent denial of PTD benefits for a worker who may never return to work. In *Carr*, the Department was required to provide the claimant with notice, the basis for a suspension of benefits, and an opportunity to respond either orally or in writing. 65 Or App at 124. Minimal due process was required in *Carr* because the claimant faced only a maximum interruption in benefits of six weeks. *Id.* at 120. However, a permanent denial of PTD benefits, which is the case here, is a much more grievous loss and, accordingly, deserves significantly more procedural protection. The majority fails to appreciate the magnitude of the interest at stake here and, thus, fails to accord claimant's interest sufficient weight in the balancing process.

As to the risk that a worker will be deprived erroneously of a protected interest, the majority reasons that the process due a worker should be shaped by the nature of the determination to be made. Accordingly, the majority reasons that the safeguards of live testimony, rebuttal evidence, and cross-examination are unnecessary because PTD determinations turn primarily on medical and vocational facts and that **<159 Or App 254/255>** written reports submitted as part of the reconsideration process are a meaningful way to present those kinds of facts. I do not agree with the majority's characterization of PTD determinations as sterile proceedings devoid of emotional content in which credibility determinations are not crucial to the fair determination of a claim. ORS 656.206(3) requires a worker to prove not only permanent total disability (medical facts) but also a willingness to seek regular gainful employment and that reasonable, though unsuccessful, efforts have been made to attain such employment. In the absence of that evidence, a claimant's case for PTD benefits cannot succeed. Carrying the burden of proof on the latter two requirements will depend, for the most part, on a calculation of the worker's veracity.

In *Mathews*, the Supreme Court stated that, where credibility and veracity are important to the generality of cases, "'written submissions are a wholly unsatisfactory basis for decision.'" 424 US at 344 (quoting *Goldberg*, 397 US at 269). We should not ignore that admonition here. Only by allowing the ALJ to observe a claimant's credibility and veracity first hand and on the record is there an assurance of reliability necessary to satisfy the dictates of due process.

The risk of an erroneous deprivation of benefits is also heightened by the evidence used in this case. As noted above, the majority asserts that PTD determinations turn primarily on medical facts. Yet, here, the Department's finding of residual functional capacity in the reconsideration proceeding is based on medical reports prepared by doctors who viewed a surveillance video of claimant--a form of non-medical hearsay. *Libett v. Roseburg Forest Products*, 130 Or App 50, 52, 880 P2d 935 (1994), *rev den* 320 Or 507 (1995). Concededly, the ALJ would also not be bound by the rules of evidence under ORS 656.283(7). However, the Department's reliance on the doctors' review of nonmedical hearsay is too far attenuated from claimant's constitutional right to confront witnesses against him. The result is a substantial risk of an erroneous deprivation of claimant's protected interest. The opportunity to cross-examine witnesses on the record would allow claimant to establish critical facts such as when the video was made, how it was edited, who appears in the video, and the context of the activity filmed--facts claimant **<159 Or App 255/256>** could not have meaningfully challenged at the time of reconsideration.

The remaining task is to balance the risk that a claimant will be deprived erroneously of a significant protected interest in PTD benefits against the government's interest and the administrative burden created by the additional safeguards proposed. The majority characterizes the cost of additional safeguards as not insubstantial. That seems an odd conclusion, considering that the system of full adjudicative hearings has operated for years without significant complaint about the cost. In any event, based on my conclusion that, under the current procedures there is a high risk of an erroneous deprivation and that a full adjudicative hearing is necessary to defeat that risk, I would conclude that any significant additional cost is justified.

When life-long benefits are at stake, denying an injured worker the opportunity to have all of the evidence, including the worker's veracity, evaluated in an adjudicative hearing, unfairly distorts the system against the worker so significantly that it violates the worker's right to due process of law.

For the foregoing reasons, I respectfully dissent.

I join in Judge Wollheim's dissent.

Wollheim, J., joins in this dissent.

WOLLHEIM, J., dissenting.

I join in Judge De Muniz' dissent but write separately for two reasons. The first is to articulate my own difficulties with the majority's opinion. The second is to highlight what I perceive to be the systematic erosion of due process rights in Oregon's Workers' Compensation Law.

I take issue with the majority on three points, the first of which is its *ad hoc* application of the three-part balancing test found in *Mathews v. Eldridge*, 424 US 319, 335, 96 S Ct 893, 47 L Ed 18 (1976). The majority acknowledges the difference between *Mathews* and the case at bar, concluding that *Mathews* does not control in this situation. 159 Or App at 244-45. The majority nevertheless deconstructs petitioner's argument using *Mathews* as its primary source. As applied narrowly to this case, I do not believe it is correct for **<159 Or App 256/257>** this court to minimize the application of *Mathews* but then use a select portion of its analysis with no regard for the remaining totality of circumstances in which that analysis applied. At its inception, the *Mathews* test--allocating due process by balancing the private interest affected, the risk of erroneous deprivation *vis-a-vis* the value of additional safeguards, and the government's interest in administrative efficiency--was informed by, and drew its vitality from, the administrative context that necessitated its creation. The majority correctly ascertains that close parallels exist between Mathews and the case before us now. 159 Or App at 244-45. Rather than ignoring those parallels, we should compare them and acknowledge that under the totality of *Mathews*, we lack, as a threshold matter, many of the components that helped the *Mathews* court ultimately hold that the process in that case was adequate.

In *Mathews*, less process was needed before terminating the petitioner's benefits because of the opportunity for a post-termination evidentiary hearing and judicial review. 424 US at 349. That option does not exist for claimant here. In *Mathews*, the petitioners worked with an "open-file" system that allowed them to submit new evidence at any time and often resulted in additional medical examinations. 424 US at 347. That right also does not exist for claimant here. My point is that if we are to engage in "judicial balancing," then we should employ some standard to which we can refer and, through careful comparison, calibrate our means of measurement, whatever they might be. In this case, if that standard is to be *Mathews*, then by comparison, claimant here begins in a system already heavily weighted against him through paucity of process. And if the standard is to be something other than *Mathews*, then the majority has yet to articulate it.[1]

My second point of contention with the majority's opinion is its characterization of the cross-examination process at hearing. This issue is important because the cross-examination of experts at an extent of disability hearing is a **<159 Or App 257/258>** critical underpinning of the majority's conclusion. The majority's assumption is that whether an injured worker is permanent totally disabled depends largely on written medical and vocational reports. 159 Or App at 239, 243-44. In order to conclude that these expert reports are reliable, the majority assumes that the experts must be made available for cross-examination at the extent of disability hearing. 159 Or App at 238-39. The majority's conclusion is that due process does not entitle a claimant to orally present evidence at hearing because the determination to be made is based largely on written expert reports, subject to cross-examination. 159 Or App at 246.

The majority is correct that vocational experts can be cross-examined at an extent of disability hearing if the expert's report was submitted at reconsideration. *Rogue Valley Medical Center v. McClearen*, 152 Or App 239, 952 P2d 1048, *rev den* 327 Or 123 (1998). The same, however, cannot be said for medical experts. ORS 656.283(7) provides, in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing * * *."

Precision Castparts Corp. v. Plummer, 140 Or App 227, 231, 914 P2d 1140 (1996), is the first case that considered the limitation on evidence at an extent of disability hearing:

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[1] The recent Supreme Court decision in *American Mfrs. Mut. Ins. Co. v. Sullivan*, ___ US ___, ___ S Ct ___, ___ L Ed 2d ___ (March 3, 1999), does not alter my objections. In *Sullivan*, as in *Mathews*, the petitioners had the right to a full post-termination evidentiary hearing. Claimant here has no similar right.

> "The unmistakable import of the text of ORS 656.283(7) is that *any* evidence, including a claimant's testimony concerning the notice of closure or reconsideration order, is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made a part of the reconsideration record." (Emphasis in original.)

The majority correctly cites OAR 438-007-0005(3), a rule that expressly requires a medical expert submit to cross-examination if that expert's report is submitted at hearing.[2] However, the administrative rule is inconsistent with ORS 656.283(7). While the Board has the authority to interpret **<159 Or App 258/259>** statutory terms, the Board "may not, by its rules, amend, alter, enlarge or limit the terms of a statute." *Cook v. Workers' Compensation Department*, 306 Or 134, 138, 758 P2d 854 (1988). Further, the Board's "authority [to adopt rules] does not include the power to adopt rules that are inconsistent with statutes." *Franzen v. Liberty Northwest Fire Ins. Co.*, 154 Or App 503, 507-08, 962 P2d 729 (1998).

In contrast, the cross-examination of vocational experts exists only because this court held that ORS 656.287(1) created an express exception to ORS 656.283(7). *McClearen*, 152 Or App at 244-45. That outcome helps illustrate why medical expert cross-examination in extent of disability cases is as it is: where there is no statutory authorization and no exception to the evidentiary prohibitions of ORS 656.283(7) exists, no cross-examination is allowed. There is no statutory authority to cross-examine a medical expert at an extent of disability hearing.

For these reasons, I believe that OAR 438-007-0005(3), to the extent that it allows for cross-examination of a medical expert at an extent of disability hearing, is invalid because the rule is inconsistent with ORS 656.283(7). Further, if no cross-examination of a medical expert is allowed at an extent of disability hearing, then part of the majority's premise collapses, defeating, in turn, its conclusion.

My third complaint is that the majority miscasts the limitations placed on the process of determining permanent total disability (PTD) as "ones of form, not substance." 159 Or App at 239. On the contrary, under Oregon statutes and case law, when we limit the exploration of PTD issues to written arguments and reports, we cannot help but limit the substance of what we discover. Two reasons for this are the "odd-lot" doctrine and ORS 656.206(3).

In *Welch v. Banister Pipeline*, 70 Or App 699, 701, 690 P2d 1080 (1984), we explained that:

> "Under [the odd-lot doctrine,] a disabled person may remain capable of performing work of some kind but still be permanently disabled due to a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Such nonmedical considerations include age, education, adaptability to nonphysical labor, **<159 Or App 259/260>** mental capacity and emotional condition, as well as the conditions of the labor market."

In other words, whether a person is PTD under the odd-lot doctrine requires inquiry into a claimant's ability to "sell his services on a regular basis in a hypothetically normal labor market." *Harris v. SAIF*, 292 Or 683, 695, 642 P2d 1147 (1982). No doubt, vocational experts can establish boundaries for the "normal" labor market, but I question their ability to measure absolutely the non-medical variables that can hamper an individual's efforts to "sell his services" within that market. My doubts are aggravated by ORS 656.206(3), which not only places on claimants the burden of proving PTD but also requires them to demonstrate both their willingness to seek regular employment and the reasonableness of their efforts to that end. Taken together, these factors do not contribute to the creation of a "sharply focused and easily documented decision" like the one at the heart of *Mathews*. 424 US at 343. Instead they create a situation where "a wide variety of information may be deemed relevant, and issues of witness credibility and veracity often are critical to the decision making process. * * * [I]n such circumstances 'written submissions are a wholly unsatisfactory basis for decision.'" *Id.* at 343-44.

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[2] It is undisputed that a party has the right to cross-examine a medical expert when the issue is not the extent of disability, *e.g.* at a compensability hearing.

As pointed as my disagreements with the majority are, a broader basis for my resistance to this case stems from what I perceive to be a general devolution of due process rights in Oregon Workers' Compensation Law. A brief review of the Workers' Compensation Law demonstrates this erosion.

At the turn of the century, an injured worker's sole recourse in Oregon was an often-difficult action at law. Recovery was impeded by a number of common law doctrines that shifted the risk of an on the job injury to the worker while protecting the profits that the worker generated for the employer from tort liability. But even under that system, the worker had the right to a day in court and the right to personally be heard.

In 1913, this state adopted its first workers' compensation law. Or Laws 1913, ch 112. Its preamble provided, in part:

> **159 Or App 261>** "The State of Oregon recognizes that the prosecution of the various industrial enterprises which must be relied upon to create and preserve the wealth and prosperity of the state involves the injury of large numbers of workmen, resulting in their partial or total incapacity or death * * *." ORS 656.004 (1979).[3]

The purpose of the law was to make injuries arising out of and in the course and scope of employment a valid cost of doing business in Oregon. The law removed the common law impediments to industrial tort recovery for those workers not covered under the law and provided an alternative remedy for those the law covered. The new law was voluntary; an employer had to elect to be covered. ORS 656.002 to 656.034 (1963). The new law augmented, rather than supplanted, an injured worker's ability to recover from the employer by creating an alternative forum within which to seek redress. It established a state commission to act as insurer, administrator, and quasi-adjudicator of on the job injuries. It created automatic compensation for industrial injuries, rigid benefit schedules, and an employer-supplied accident fund. Importantly, it retained the feature allowing injured workers personally to tell their stories. While this right occurred in an administrative setting, it maintained the inherent due process protections of traditional adjudicatory forums. If the injured worker was dissatisfied by a decsion made by the State Insurance Accident Commission, the injured worker had the right to appeal to the circuit court. ORS 656.286(1) (1963). An injured worker was entitled, as a matter of right, to a jury trial on any question of fact and the court was bound by that finding. ORS 656.288(3) (1963) and 656.290(1) (1963).

In 1965, however, those protections began incrementally to disappear with changes in the law. Except for injuries caused by an employer's intentional acts, workers injuried on the job were no longer permitted the option of tort actions against their employers; the Workmens' Compensation Law became their exclusive remedy. ORS 656.018. Coverage against injury became compulsory for all. An injured worker lost the right to a jury trial after review by the newly created **<159 Or App 261/262>** Workmens' Compensation Board. ORS 656.712 (1965). In place of a jury trial the circuit court would review the entire record. The judge could receive additional evidence and could "make such disposition of the case as the judge determines to be appropriate." ORS 656.298(6) (1965).

In 1977, the legislature eliminated review by the circuit court. Instead the Court of Appeals directly reviewed orders by the Workers' Compensation Board.[4] This court could consider additional evidence and dispose of each case under *de novo* review. ORS 656.298 (1977). Ten years later, in 1987, *de novo* review was eliminated. ORS 656.298(6) (1987) (now numbered ORS 656.298(7)). Now we review the Board's decisions only to determine whether they are supported by substantial evidence and for errors of law. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Today, there is no opportunity for an injured worker to have a "day in court" before the worker's peers or anyone else, concerning the extent of the worker's disability. Initial disability determinations are not based on personal testimony but rather on paper trails created within the

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[3] This language remained until it was repealed in 1981 and replaced by ORS 656.012.

[4] In 1977, the legislature changed the name of the Board from Workmens' Compensation Board to the Workers' Compensation Board. Or Laws 1977, ch 109, section 3.

Workers' Compensation Division or collected by the employer. ORS 656.268. If the injured worker disagrees with a determination, a request for reconsideration will produce only another record review. The process specifically excludes the injured worker, or a representative, from personally appearing unless the agency asks the worker to appear, an invitation that is rarely, if ever, extended. OAR 436-030-0115(2). Thus, the determination of the extent of an injured worker's disability is made without the maker of that determination ever seeing or hearing the injured worker.

Injured workers may appeal the resulting reconsideration orders to an administrative law judge, but only evidence presented at reconsideration may be submitted at the subsequent hearing. ORS 656.283(7). The result is a Catch-22 of epic proportions: at the point where injured workers would traditionally look into the face of an impartial adjudicator and tell their stories, they are precluded from doing so **<159 Or App 262/263>** because they could not do so at the previous reconsideration proceeding. These things should not be. Due process requires more. Simple justice requires more.

We live in a time of unparalleled prosperity, a prosperity built, I believe, largely on the backs of working men and women. The 1913 Oregon legislature recognized this fact when it declared that the wealth and prosperity of this state was created by industrial enterprises and that those enterprises caused injury to a large number of workers. Back in 1913, if one on those backs broke the injured worker was entitled to a day in court to tell what happened and how the injury impacted the injured worker's capacity to earn a living. Now, however, should one of those backs break, our system of industrial justice no longer extends to the injured that most elemental of courtesies: a moment to relate, in person, the extent of their injury to those appointed to judge the extent of their disability. In our attempt at efficiency, we have succeeded only in eliminating from the dialogue a small vestige of our humanity. We have created order without asking if it is, in fact, *good* order. The result, I think, moves us toward a bureaucratic ghetto wherein the voices of injured workers are silenced by a system that resembles justice, but denies the power thereof.

I, therefore, dissent.

De Muniz, J., joins in this dissent.

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