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

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

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CITE AS

51 Van Natta ____ (1999)

In the Matter of the Compensation of
JESUS ZARZOSA, Claimant
WCB Case No. 98-03909
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that awarded an assessed attorney fee of $3,000. SAIF also moves for remand. Claimant cross-requests review, requesting an increased attorney fee. 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.

Claimant requested a hearing challenging SAIF's denials of his injury claim for an L5-S1 disc herniation. The ALJ found that claimant had established the compensability of his L5-S1 disc herniation, and directed SAIF to accept and process the claim. The ALJ also awarded 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 apply each of the factors in OAR 438-015-0010(4) and failed to make specific findings of fact regarding each factor in awarding the assessed attorney fee.[1] 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). 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 OAR 438-015-0010(4) 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 as reflected by the record, hearing, deposition and telephone arguments, as well as the complexity of the issues, 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); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).

Claimant cross-requests review, requesting an increased attorney fee. SAIF contends that a fee greater than $3,000 is not justified.

We determine the amount of claimant's counsel's attorney fee for services at hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute were compensability of claimant's L5-S1 disc herniation and whether claimant's injury occurred in the course and scope of his employment. Thirty-four exhibits were admitted in evidence. Of those admitted exhibits, at least ten were submitted or generated by claimant's counsel. There was one deposition with a transcript of 49 pages. The hearing lasted two and one-half hours and the transcript consists of 66 pages. Claimant testified on his own behalf and three witnesses testified on behalf of SAIF. Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures.

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[1] SAIF is not contending that the $3,000 attorney fee award is excessive.

As compared to typical compensability cases, the issue here was of average complexity. Because claimant's L5-S1 disc herniation 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 attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were presented at hearing. Furthermore, given the contradictory medical opinions, there was a risk that claimant's counsel might go uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we agree with the ALJ that $3,000 is a reasonable fee for claimant's attorney's services at hearing. We therefore affirm the ALJ's attorney fee award. 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 regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 17, 1999 is affirmed.

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

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Varah*, 160 Or App 254 (1999). The court has reversed our prior order, *Joni M. Varah*, 50 Van Natta 1124, *on recon* 50 Van Natta 1360 (1998), that awarded claimant a carrier-paid attorney fee under ORS 656.386(1) when the SAIF Corporation removed the word "resolved" from its Notice of Acceptance in response to claimant's hearing request. Reasoning that, at most, the use of "resolved" in the acceptance notice *implied* that SAIF might refuse to pay future benefits for claimant's condition, the court concluded that such an *implication* is not *express* and, as such, does not trigger the statutory entitlement to a carrier-paid attorney fee pursuant to ORS 656.386(1). Determining that we erred in awarding an attorney fee under ORS 656.386(1), the court has remanded.

Consistent with the court's opinion, we hold that claimant is not entitled to an attorney fee award pursuant to ORS 656.386(1). Accordingly, the ALJ's order dated November 14, 1997 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS SHERMAN, Claimant
WCB Case No. 98-03871
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) concluded that the Hearings Division had jurisdiction over claimant's request for hearing; and (2) set aside its denial of claimant's current low back condition. On review, the issues are jurisdiction and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer filed a motion to dismiss claimant's request for hearing on the ground that the Hearings Division did not have jurisdiction because the issue involved a medical question subject to the jurisdiction of the Department of Consumer and Business Services (DCBS). The ALJ concluded that the insurer's March 19, 1998 denial placed in issue the compensability of claimant's current condition and, therefore, the Hearings Division had jurisdiction. The ALJ denied the motion to dismiss.

On review, the insurer argues that the only issue is whether claimant's ongoing medical services are related to the original accepted conditions. The insurer asserts that its denial was issued in response to requests to pay for such treatment. The insurer contends that DCBS has jurisdiction over this case.

Claimant compensably injured his low back on April 2, 1990. (Ex. 1). On May 2, 1990, the insurer accepted "[f]acet syndrome, L5 subluxation, S1 subluxation, as described by your Doctor." (Ex. 12). Claimant has continued to seek treatment periodically for low back symptoms since the work injury. On March 19, 1998, the insurer wrote to claimant:

> "Information in your file indicates that your current condition, diagnosed as multilevel degenerative disc and degenerative joint disease in the lumbar spine, and significant leg length discrepancy, is unrelated to your injury. Therefore, we must deny responsibility for your current condition.
>
> "[The insurer] will continue to provide medical benefits related to your accepted condition." (Ex. 54).

At hearing, the insurer's position was that, regardless of what claimant's present condition was, it was not part of the compensable condition. (Tr. 3, 4).

The insurer's denial said that claimant's current low back condition was "unrelated" to the compensable injury and it denied responsibility for his current condition. Under these circumstances, we agree with claimant and the ALJ that the insurer's denial constitutes a denial of claimant's current condition as well as a denial of medical services. Consequently, we retain jurisdiction over the parties' dispute. *See SAIF v. Pendergast-Long*, 152 Or App 780, *adhered to* 155 Or App 633 (1998) (where the parties disputed whether the condition for which the claimant sought treatment was compensable, the compensability of the underlying condition was at issue, and the Board had jurisdiction over the claim).

Compensability

The ALJ found that the insurer had accepted facet syndrome, a complex of symptoms of the facet joints. The ALJ concluded that the accepted facet syndrome was caused in part by preexisting degenerative disc disease. Relying on *Georgia Pacific v. Piwowar*, 305 Or 494 (1988), the ALJ reasoned that by accepting the symptoms, the insurer had accepted the cause of the symptoms. The ALJ concluded that the degenerative disc disease and resulting degenerative facet disease constituted the major contributing cause of claimant's current low back condition and the insurer could not deny those conditions.

The insurer argues that the ALJ erred by finding that its acceptance of facet syndrome included the acceptance of degenerative disc disease or degenerative facet disease that is the cause of claimant's current need for treatment. The insurer contends that claimant did not establish that his work injury remains the compensable cause of his ongoing disability or need for treatment.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Georgia Pacific v. Piwowar*, 305 Or at 501-02. In *Piwowar*, the carrier accepted a claim for a "sore back." Medical evidence showed that a preexisting disease (ankylosing spondylitis) caused the sore back, and the carrier denied compensability of that condition. *Id.* at 497. The Supreme Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, its denial of the preexisting condition constituted a "back-up" denial. *Id.* at 501-02.

On the other hand, if the carrier's acceptance is for a separate condition, the rule of *Piwowar* does not apply. *Boise Cascade Corp. v. Katzenbach*, 104 Or App 732, 735 (1990), *rev den* 311 Or 261 (1991). In *Katzenbach*, the court accepted the Board's finding that the claimant's wrist strain and avascular necrosis were separate conditions. Under those circumstances, the court found that the rule of *Piwowar* did not apply and it concluded that the carrier's acceptance of the strain was not an acceptance of a claim for avascular necrosis. *Id.* Acceptance of a particular condition does not necessarily include the cause of that condition. *Granner v. Fairview Center*, 147 Or App 406, 410 (1997).

Unlike *Piwowar*, the insurer in this case accepted a specific condition, not merely symptoms. *Compare Janet R. Christensen*, 50 Van Natta 396 (1998) (the carrier accepted "low back pain r/o HNP"; the "low back pain" was caused in part by spinal stenosis and degenerative disc disease and, therefore, the carrier's acceptance included those conditions). Here, the insurer limited its acceptance to "[f]acet syndrome, L5 subluxation, S1 subluxation, as described by your Doctor." (Ex. 12).

Moreover, we find that claimant's reliance on *Piwowar* is misplaced because the medical evidence indicates that degenerative disc disease and degenerative facet disease are not the same conditions as the accepted conditions of facet syndrome, L5 subluxation and S1 subluxation. In April 1990, claimant was diagnosed with facet syndrome, L5 subluxation and S1 subluxation by Dr. Gilliland, a chiropractic physcian. (Ex. 2). Claimant's current low back condition has been diagnosed by Dr. Schilperoort as multilevel degenerative disc and degenerative facet joint disease in the lumbar spine. (Ex. 53-4). Dr. Weinman, claimant's treating physician, agreed with Dr. Schilperoort. (Ex. 56). Dr. Weinman testified that claimant's degenerative disc disease was the main reason for claimant's low back pain and need for treatment. (Ex. 57-10). On the other hand, Dr. Weinman did not believe claimant had facet syndrome, which he explained was irritation of the facet joints. (Ex. 57-7).

Dr. Schilperoort testified that he did not know with any precision what claimant's chiropractor meant when he diagnosed facet syndrome. (Ex. 59-23). He did not believe, however, that "facet syndrome" was the same as degenerative joint disease. (Ex. 59-24). Based on the reports from Drs. Weinman and Schilperoort, we conclude that claimant's current degenerative disc and degenerative facet disease are not the same conditions as the accepted conditions of facet syndrome, L5 subluxation and S1 subluxation.

Furthermore, although the insurer's acceptance referred to "[f]acet syndrome, L5 subluxation, S1 subluxation, *as described by your Doctor*" (Ex. 12; emphasis supplied), we find no evidence that Dr. Gilliland described claimant's symptoms as related to degenerative disc disease or degenerative facet disease. At the time the insurer accepted the claim on May 2, 1990, claimant was being treated by Dr. Gilliland. His records of treatment for claimant do not refer to degenerative disc disease or degenerative facet disease. (Exs. 3, 4, 5, 7, 8, 9, 10, 11). X-rays taken on April 23, 1990 showed "relatively mild" degenerative disease, apparently at L5-S1. (Ex. 6). Although that x-ray report was reviewed by Dr. Gilliland on April 24, 1990 (Ex. 8), he did not subsequently include a diagnosis of degenerative disc disease or degenerative facet disease in his reports.[1]

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[1] We note that, after the insurer accepted the claim, Dr. Perry diagnosed claimant with a low back strain with degenerative disc disease at L5-S1. (Ex. 14-2). Because Dr. Perry did not examine claimant until after the insurer accepted the claim, we conclude that Dr. Perry's reference to degenerative disc disease is not included in the portion of the insurer's acceptance referring to conditions "*as described by your Doctor.*" (Ex. 12; emphasis supplied).

In sum, we conclude that the medical evidence establishes that claimant's current degenerative disc disease and degenerative facet disease are not the same conditions as the accepted conditions of facet syndrome, L5 subluxation and S1 subluxation. We conclude that *Piwowar* does not apply to the facts of this case. *See Katzenbach*, 104 Or App at 735. Consequently, we proceed to examine the merits of the insurer's March 19, 1998 denial.

As we discussed earlier, claimant's current low back condition has been diagnosed as multilevel degenerative disc and degenerative facet joint disease in the lumbar spine. (Exs. 53-4, 56). The insurer denied those conditions, as well as claimant's significant leg length discrepancy,[2] as being unrelated to his accepted injury. (Ex. 54). Because of the multiple possible causes of claimant's current low back condition, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

The medical evidence indicates that claimant's degenerative disc and degenerative facet joint disease in the lumbar spine preexisted the April 1990 work injury. Dr. Weinman testified that the degenerative changes in claimant's lumbar spine preexisted the April 2, 1990 injury. (Ex. 9). Dr. Schilperoort agreed that the degenerative disc and degenerative facet joint disease in the lumbar spine preexisted the work injury. (Ex. 59-22, -23). Dr. Weinman testified that the main reason for claimant's continued low back pain and need for treatment was the degenerative disc disease. (Ex. 57-10). Dr. Weinman had previously agreed with Dr. Schilperoort's March 14, 1998 report that indicated the major contributing cause of claimant's current low back condition and need for treatment was the preexisting multilevel degenerative joint and degenerative disc disease. (Exs. 53-4, 56). We find no medical evidence that establishes compensability of claimant's current low back condition as related to the original claim or as independently compensable. Consequently, we uphold the insurer's denial of claimant's multilevel degenerative disc and degenerative facet joint disease in the lumbar spine.

ORDER

The ALJ's order dated February 1, 1999 is affirmed in part and reversed in part. The insurer's denial of claimant's current low back condition is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

[2] The denial of the leg length discrepancy was not contested at hearing or on review.

July 7, 1999 Cite as 51 Van Natta 1215 (1999)

In the Matter of the Compensation of
SHAWN M. SPRING, Claimant
WCB Case No. 98-06132
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

The insurer has requested reconsideration of our June 17, 1999 Order on Review. Specifically, the insurer contends that we erred in affirming that portion of the ALJ's order that declined to allow the insurer to depose Dr. Tanabe. After considering the insurer's motion, its memorandum in support, claimant's response, and the insurer's reply, we have nothing further to add to our prior order.

Accordingly, our June 17, 1999 order is withdrawn. On reconsideration, we adhere to and republish our June 17, 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
LINDA R. BAROCIO, Claimant
WCB Case Nos. 98-01494 & 98-00212
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded a $3,500 fee for claimant's counsel's services on review. SAIF also moves for remand. Claimant cross-requests review, seeking sanctions for an allegedly frivolous appeal. Alternatively, claimant moves for remand. On review, the issues are remand, attorney fees, and sanctions.

We deny SAIF's motion for remand and claimant's motions for sanctions and remand. We also adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's compensability denial of her right knee medial meniscus injury. Following the hearing, the ALJ set aside the denial and directed SAIF to process the claim. The ALJ also assessed an attorney fees of $3,500 pursuant to ORS 656.386(1).

On review, SAIF argues that the ALJ failed to make specific findings with regard to the factors set forth in the rule and that her explanation for the $3,500 fee award under ORS 656.386(1) 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. 50 Van Natta at 2332. Consequently, the motion to remand is denied.

Here, the ALJ cited to the applicable rule and identified the factors considered in determining the fee. The ALJ explained that, in awarding the $3,500 fee, the value of the interest involved, the complexity of the issues involved, the benefit secured for the represented party, the skill of both litigants, the adversarial nature of the proceedings, and the risk that claimant's attorney's efforts may go uncompensated were particularly considered. 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 her counsel's services on review. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1988).

ORDER

The ALJ's order dated February 5, 1999 is affirmed.

In the Matter of the Compensation of
WOODROW T. BERNARD, Claimant
WCB Case Nos. 98-07556 & 98-04544
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) affirmed that portion of an Order on Reconsideration that awarded 38 percent (121.6 degrees) unscheduled permanent disability for claimant's contact dermatitis condition; and (2) awarded 8 percent (12 degrees) scheduled permanent disability in lieu of all prior scheduled permanent disability awards. Claimant cross-requests review of those portions of the ALJ's order that: (1) reduced his award of scheduled permanent disability for loss of use or function of each of his forearms from 38 percent (57 degrees), as granted by the Order on Reconsideration, to the single award of 8 percent (12 degrees) scheduled permanent disability; and (2) declined to award claimant's counsel an attorney fee pursuant to ORS 656.382(2). On review, the issues are extent of unscheduled and scheduled permanent disability and attorney fees. We modify in part, reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In November 1996, claimant, an operating room technician, developed contact dermatitis on his hands and forearms that later spread to the face and neck. In January 1997, the employer accepted the occupational disease claim, but limited its acceptance to the bilateral forearms.

On March 3, 1998, the employer issued a Notice of Closure that awarded no permanent disability. Claimant requested reconsideration, which resulted in a dermatologist, Dr. Bell, performing a medical arbiter examination. Based on the arbiter's report, a May 14, 1998 Order on Reconsideration awarded 15 percent scheduled permanent disability for each forearm. The employer requested a hearing in June 1998.

The claim was subsequently reopened for aggravation and then reclosed by Notice of Closure in August 1998. It awarded no permanent disability. The closure notice specifically stated that claimant was "entitled to no additional permanent partial disability in excess of that granted by the May 14, 1998 Order on Reconsideration." (Ex. 14A). Claimant requested reconsideration.

On September 14, 1998, the employer expanded its acceptance of claimant's contact dermatitis condition to include the face and neck. (Ex. 16). An additional medical arbiter's examination was performed in October 1998, this time by Dr. Larsen, another dermatologist. Based on that examination, a November 18, 1998 Order on Reconsideration awarded 38 percent scheduled permanent disability for each forearm and 38 percent unscheduled permanent disability. (Ex. 24). The employer requested a hearing from that reconsideration order. Claimant also cross-requested a hearing regarding unscheduled and scheduled permanent disability. All hearing requests from the reconsideration orders were consolidated for hearing.

The ALJ first addressed the issue of scheduled permanent disability. In doing so, the ALJ rejected claimant's argument that the 15 percent bilateral forearm awards in the May 1998 reconsideration order represented the minimum scheduled award because the employer had stated in the August 1998 Notice of Closure that claimant was not entitled to permanent disability in excess of that granted in the May 1998 Order on Reconsideration. The ALJ held that the employer's acknowledgment of the permanent disability award in the May 1998 reconsideration order did not bar or preclude the employer from challenging the permanent disability award in that order.

The ALJ then determined that OAR 436-035-0115(5) did not apply to the rating of scheduled permanent disability because claimant's allergic contact dermatitis was not limited to the body parts

listed in the rule and was an allergic systemic reaction.[1] Therefore, the ALJ rated scheduled permanent disability pursuant to OAR 436-035-0450.[2] Applying that rule, the ALJ determined that claimant was entitled to 8 percent scheduled permanent disability under subsection (b).

The ALJ then addressed unscheduled permanent disability, noting that OAR 436-035-0110(5) stated that contact dermatitis for an unscheduled body part was rated under OAR 436-035-0440. The ALJ found that subsection 2 of the latter rule controlled the rating of unscheduled permanent disability for claimant's face and neck, not subsection 1, because there was no medical evidence that claimant developed an immunological reaction to physical, chemical or biological agents.[3] The ALJ then awarded

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[1] OAR 436-035-0110(5) provides that:

"Dermatological conditions, including burns, which are limited to the arm, forearm, hand, fingers, or thumb are rated according to the body part affected. The percentages indicated in the classes below are applied to the affected body part(s), e.g. a Class 1 dermatological condition of the thumb is 3% of the thumb, or a Class 1 dermatological condition of the hand is 3% of the hand, or a Class 1 dermatological condition of the arm is 3% of the arm. Contact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is rated pursuant to OAR 436-035-0450. Contact dermatitis for an unscheduled body part is rated pursuant to OAR 436-035-0440."

[2] That rule, which deals with impairment of the immune system, provides that:

"When exposure to physical, chemical, or biological agents has resulted in the development of an immunological response, impairment of the immune system shall be valued as follows:

"(a) 3% when the reaction is a nuisance but does not prevent most regular work related activities; OR,

"(b) 8% when the reaction prevents some regular work related activities; OR,

"(c) 13% when the reaction prevents most regular work related activities."

[3] OAR 436-035-0440 provides:

"(1) If the worker has developed an immunologic reaction to physical, chemical or biological agents, impairment will be valued pursuant to OAR 436-035-0450.

"(2) Impairments of the integumentary system shall be rated according to the following classes:

"(a) Class 1 -- (3 percent Impairment):

"(A) Signs or symptoms of skin disorder are present; and

"(B) With treatment, there is no limitation, or minimal limitation, in the performance of work related activities, although exposure to certain physical or chemical agents might increase limitation temporarily.

"(b) Class 2 -- (15 percent Impairment):

"(A) Signs and symptoms of skin disorder are present; and

"(B) Intermittent treatment is required; and

"(C) There is mild limitation in the performance of some work related activities.

"(c) Class 3 -- (38 percent Impairment):

"(A) Signs and symptoms of skin disorder are present; and

"(B) Continuous treatment is required; and

"(C) There is moderate limitation in the performance of many work related activities.

"(d) Class 4 -- (68 percent Impairment):

"(A) Signs and symptoms of skin disorder are present; and

"(B) Continuous treatment is required, which may include periodic confinement at home or other domicile; and

"(C) There is moderate to severe limitation in the performance of many work related activities.

"(e) Class 5 -- (90 percent Impairment):

"(A) Signs and symptoms of skin disorder are present; and

claimant 38 percent unscheduled permanent disability under OAR 436-035-0440(2), finding that claimant was entitled to class III impairment under that rule, based on Dr. Larsen's medical arbiter's report.

On review, claimant again contends that he is entitled to no less than 15 percent bilateral scheduled forearm permanent disability based on the employer's statement in the August 1998 Notice of Closure that he was not entitled to additional permanent disability beyond the 15 percent bilateral award in the May 1998 Order on Reconsideration. We adopt, however, the ALJ's reasoning in rejecting claimant's contention at hearing. The employer's statement was only an acknowledgment of the current status of the claim while the award of scheduled permanent disability in the May 1998 Order on Reconsideration was being contested. Therefore, we disagree with claimant's assertion that there is a minimum scheduled permanent disability level beneath which we cannot reduce claimant's scheduled disability.

We now turn to the merits of the scheduled permanent disability issue. The employer asserts that claimant is not entitled to a scheduled award because the dermatitis on his arms is rated under OAR 436-035-0450, an unscheduled disability standard. We agree.

In *Paul A. Welburn*, 49 Van Natta 1117 n.1 (1997), we held that OAR 436-035-0110(5) provides for a scheduled rating only if the condition to be rated does *not* fall within the rule for an unscheduled award. Here, claimant's upper extemity dermatitis does fall within a rule for an unscheduled award, OAR 436-035-0450. Therefore, claimant's dermatitis in the upper extremities is rated under OAR 436-035-0450, not OAR 436-035-0110(5). It follows that a scheduled award is not available in light of the restriction set forth in OAR 436-035-0110(5).

Accordingly, we reverse the ALJ's award of scheduled permanent disability. However, claimant is entitled to unscheduled permanent disability under OAR 436-035-0450, provided that his dermatitis condition qualifies for such an award under that rule. Because we agree with the ALJ's reasoning that claimant's condition qualifies for 8 percent impairment under OAR 436-035-0450(1)(b), we award 8 percent unscheduled permanent disability instead of the ALJ's 8 percent scheduled award.

The employer next challenges the ALJ's finding of 38 percent impairment under OAR 436-035-0440, asserting that, because claimant developed an "immunological reaction" to physical, chemical or biological agents, unscheduled permanent disability should be rated according to subsection (1) of that rule, which provides that, in such cases, impairment is valued pursuant to OAR 436-035-0450. The ALJ rejected the employer's argument because there was no evidence that claimant developed an immunological reaction. The employer contends that we should not require medical evidence to prove that an allergic reaction is synonymous with an immunological response. The employer cites a definition of "immunology" from Dorland's Medical Dictionary (25th ed., 1980) as support for its assertion. There, "immunology" is defined as "the science of dealing with aspects of immunity, including allergy, hypersensitivity, etc."

In *SAIF v. Calder*, 157 Or App 224, 227 (1998), the court reversed our order that granted the claimant scheduled permanent disability for the right arm. In making our decision, we had referred to a medical dictionary to determine that the claimant's coracobrachial ligament (which had been mentioned in the claimant's surgeon's operative report as having been "preserved") was a ligament in the arm involved in shoulder flexion and, as such, constituted a loss of arm strength.

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 us to refer to a medical dictionary for the purpose of identifying the coracobrachial ligament because the dictionary definition

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"(B) Continuous treatment is required, which necessitates confinement at home or other domicile; and

"(C) There is severe limitation in the performance of work related activities.

"(3) If either too little or too much tearing results in a worker's being restricted from regular work, and the condition is not an immunological reaction, a value shall be assigned as follows:

"(a) 3 percent when the reaction is a nuisance but does not prevent most regular work-related activities; or

"(b) 8 percent when the reaction prevents some regular work-related activities; or

"(c) 13 percent when the reaction prevents most regular work-related activities."

was capable 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 the medical opinions neither indicated that the ligament had been affected by the claimant's injury/surgery nor that the claimant had suffered a loss of arm strength, the court concluded that our opinion went beyond the dictionary definition and also beyond the reasonable inferences that could be drawn from the medical evidence. Determining that the medical evidence did not support our finding that the claimant experienced a loss of arm strength, the court remanded for reconsideration *Id.* at 228.

Here, while we may take notice of Dorland's definition of "immunology" as a science that concerns allergies, this does does not necessarily mean that an allergic reaction is synonymous with an immunological reaction. In accordance with the *Calder* rationale, we conclude that there must be medical evidence in the record that claimant experienced an "immunological reaction" to physical, chemical or biological agents in order for claimant's unscheduled impairment in the face and neck to be rated under subsection 1 of OAR 436-035-0440. Because this record lacks evidence that an allergic reaction constitutes an immunological reaction, we agree with the ALJ that unscheduled impairment for the face and neck is rated, not under subsection 1, but rather under subsection 2. Pursuant to that subsection, claimant is entitled to class III impairment (38 percent) based on Dr. Larsen's assessment. Thus, we affirm that part of the ALJ's order.

We now turn to attorney fees. Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (the difference between the 8 percent scheduled permanent disability granted by the ALJ's order and the 8 percent unscheduled permanent disability granted by our order), not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055.

Claimant also prevailed over the insurer's request for hearing to reduce the unscheduled permanent disability award. Even though claimant's scheduled disability award was ultimately eliminated as as result of the employer's request for hearing, because each award was for separate and distinct body parts, claimant's attorney is entitled to an assessed fee with regard to the unscheduled permanent disability award pursuant to ORS 656.382(2). *See Roseburg Forest Products v. Boqua*, 147 Or App 197, 202 (1997); *Debra Cooksey*, 44 Van Natta 2197, 2198 (1992).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the unscheduled permanent disability award is $1,000, payable by the 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.

Finally, because we have not reduced or disallowed claimant's compensation as a result of the employer's request for review, claimant's attorney is also entitled to an assessed fee for services on review regarding the permanent disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review in obtaining an attorney fee award. *See Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated March 1, 1999 is modified in part, reversed in part and affirmed in part. In lieu of the ALJ's award of scheduled permanent disability, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award of 46 percent (147.2 degrees). Claimant's counsel is awarded an approved attorney fee equal to 25 percent of the increased compensation (8 percent unscheduled permanent disability) created by this order, not to exceed $3,800, payable directly to claimant's counsel. That portion of the ALJ's order which declined to award an attorney fee pursuant to ORS 656.382(2) is reversed. Claimant is awarded a fee of $1,000 for services at hearing regarding the permanent disability issues, payable by the employer. The remainder of the ALJ's order is affirmed. For services on review, claimant is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
LIDIA A. QUINTERO, Claimant
WCB Case No. 98-07491
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that awarded a $600 attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant injured her right elbow and forearm at work on May 4, 1998. The employer had knowledge of the injury on the day it occurred. On July 16, 1998, claimant's attorney wrote SAIF inquiring whether it was processing the May 4, 1998 injury claim. On July 23, 1998, claimant filed a written claim for the May 4, 1998 injury. Claimant's attorney filed a hearing request on September 22, 1998, raising the issue of a "de facto" denial of the May 4, 1998 claim. On September 28, 1998, SAIF accepted a "right forearm sprain" due to the May 4, 1998 injury.

A hearing was held on December 17, 1998. Among the issues raised at the hearing by claimant was entitlement to an attorney fee under ORS 656.386(1) for claimant's counsel's services in obtaining a pre-hearing rescission of a "de facto" denial of the May 4, 1998 injury claim.

At the hearing, SAIF argued that there was no "de facto" denial of the claim because the claim was accepted within 90 days of claimant's written claim. The ALJ rejected SAIF's argument, finding that an initial injury claim need not be made in writing. The ALJ concluded that a claim was made on May 4, 1998 because the employer had knowledge of the claim on that date,[1] and, furthermore, because the claim was accepted more than 90 days after that date, the claim was "de facto" denied. The ALJ then found that claimant's attorney was instrumental in obtaining SAIF's rescission of the denial because the claim was accepted only after claimant's attorney's request for hearing regarding the denial. Consequently, the ALJ awarded a $600 attorney fee pursuant to ORS 656.386(1).

On review, SAIF argues that an attorney fee cannot be awarded under ORS 656.386(1) because there was no "denied claim" as defined in ORS 656.386(1). Claimant argues that by failing to accept the claim within 90 days, SAIF denied the claim.

ORS 656.386(1) provides, in part:

> " * * * In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed.
>
> "(b) For purposes of this section, a denied claim is:
>
> "(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

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[1] 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."

"(B) A claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262 (6)(d), which the insurer or self-insured employer does not respond to within 30 days; or

"(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.

"(c) A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in timely fashion. Attorney fees provided for in this subsection shall be paid by the insurer or self-insured employer."

This case involves an initial injury claim as opposed to a "new medical condition" claim or a condition omitted from a Notice of Acceptance. Thus, ORS 656.386(1)(b)(B) and (C) do not apply. Rather, the issue is whether SAIF refused to pay "on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation."

We do not find any evidence in this record that SAIF "refused to pay on the express ground" that the condition was not compensable or otherwise did not give rise to an entitlement to compensation. In this regard, there is no response to claimant's hearing request that can be construed as an express denial of compensation. *See Kimberly Quality Care v. Bowman*, 148 Or App 292 (1997) (carrier's response to the claimant's hearing request that said that the claimant had not sustained a work-related injury or disease was an express denial). In addition, there is no other express statement in the record that can be interpreted as an express denial of compensation. Under such circumstances, we are unable to conclude that there is a "denied claim." Thus, we reverse the ALJ's award of an attorney fee under ORS 656.386(1).[2]

ORDER

The ALJ's order dated January 15, 1999 is reversed in part and affirmed in part. That portion that awarded an attorney fee pursuant to ORS 656.386(1) is reversed. The remainder of the order is affirmed.

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[2] Claimant did not contest that portion of the ALJ's order that declined to assess penalties under ORS 656.262(11). Claimant likewise does not request an attorney fee under ORS 656.382(1) for unreasonable resistance to the payment of compensation. In any event, we find insufficient evidence in the record that any compensation was unpaid. Although the record reflects that claimant required medical treatment, it is unclear whether the bill for this treatment was paid. Under such circumstances, we find no proof of unreasonable resistance to the payment of compensation. *See SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993).

In the Matter of the Compensation of
TED SOWERS, CLAIMANT
WCB Case No. TP-99004
THIRD PARTY DISTRIBUTION ORDER
Richard M. Walsh, Claimant Attorney
Travelers Ins. Co., Insurance Carrier

Reviewed by Board Members Haynes and Phillips Polich.

Claimant has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party judgment. Specifically, claimant seeks approval of an attorney fee equal to 40 percent of the third party judgment. The insurer, Travelers Property Casualty (Travelers), as the paying agent, does not oppose the petition. We find that extraordinary circumstances exist to justify the requested fee.

FINDINGS OF FACT

On July 23, 1996, claimant was involved in a low speed collision while driving a forklift for Travelers' insured. Claimant's forklift was carrying two large (four feet square) cardboard containers (totes) and pushing four other totes when it collided with another forklift carrying two totes operated by an employee of Norpac. Both drivers' fields of vision were limited. The low speed collision caused little or no damage to the cardboard totes.

Two days after the collision, claimant sought chiropractic treatment and was diagnosed with soft tissue injury to the neck and shoulder. He was referred to Dr. Stringham, M.D., who provided follow-up care. Although claimant's condition did not respond to treatment and his symptoms worsened over time, no definitive objective source of his pain and disability could be found. Objective findings of injury to his neck were limited to reduced ranges of motion.

Travelers accepted claimant's injury claim, which was eventually closed with permanent disability award totaling $26,000. Subsequently, claimant released his "non-medical service" benefits under the claim pursuant to a Claim Disposition Agreement (CDA) for $10,000. In all, Travelers paid benefits totaling $74,327.73 ($23,484.88 in medical expenses plus $50,842.85 in CDA proceeds and temporary and permanent disability benefits).

On August 7, 1997, claimant retained his present attorney to represent him in a third party claim against Norpac. He signed a retainer agreement, agreeing to pay 33 percent of any settlement if the case settled without a trial and 40 percent of all proceeds if the case went to trial. Claimant also agreed to advance all costs before or as they were incurred.

Claimant's attorney made numerous requests for a settlement conference with Norpac, who refused and maintained a "zero offer" position. Norpac's position was that claimant was more negligent than its employee because he was pushing more totes at the time of the collision. In addition, Norpac contested all of claimant's injuries and damages, contending that such a low impact collision (which only resulted in cardboard totes bumping together) could not cause any injuries or, if it did, such injuries would be very minor and temporary.

Claimant filed a third party cause of action against Norpac, seeking $271,531.83 in damages. Other than the initial filing fee, claimant was unable to advance any costs. As a result, claimant's attorney advanced all further costs of the litigation.

Claimant's attorney conducted depositions of the parties and Norpac management personnel. Extensive discovery was completed. Specifically, the management structure of Norpac and the training, corrections, and management techniques of Norpac forklift drivers and the specific driver in this case were examined in detail.

Due to the nature of claimant's soft tissue injuries, claimant's attorney had to consult with medical experts, including holding conferences with a shoulder surgeon and the two primary treating physicians. Claimant's attorney also interviewed lay witnesses at length. In addition, claimant's attorney hired an accident reconstruction expert and had numerous conferences with this expert, including spending an afternoon at the scene of the accident to reconstruct, photograph, and videotape claimant's version of the collision for presentation to the jury. Claimant's attorney incurred total costs of $11,844.44.

The trial required five days before a 12 person jury. On April 16, 1999, the jury returned with a verdict in favor of claimant for the full amount requested ($271,531.83). Less five percent for claimant's contributory negligence, the total adjusted verdict was $257,955.24. After costs of $1,753.50 were awarded, the final judgment was $259,708.73. Norpac did not appeal and paid the judgment in full on May 14, 1999.

On May 19, 1999, claimant signed an affidavit in which he asked that the Board approve a fee of 40 percent of the recovery in this case. This agreement also stated that costs incurred by his counsel would be deducted out of his portion of the settlement.

Travelers has been fully reimbursed its lien of $74,327.73 and does not oppose claimant's attorney's request for an extraordinary attorney fee of 40 percent.

CONCLUSIONS OF LAW AND OPINION

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

We have authorized extraordinary attorney fees in the past. *See Victoria A. Brokenshire*, 50 Van Natta 1411 (1998) (a 45 percent share of a $729,967.76 judgment was allowed where the case involved a complex strict product liability claim, a jury trial was required, the claimant prevailed over the defendant's appeal to the Court of Appeals, the claimant's argument was relied on by the Supreme Court in dismissing the defendant's appeal to that Court, and the paying agent did not object to the fee); *Pamela J. Jennings*, 49 Van Natta 12 (1997) (a 40 percent share of a $280,000 judgment was allowed where the case involved a complex medical negligence issue, extensive motion practice and court memorandum were necessitated due to the defendants failure to follow the usual voluntary methods of obtaining discovery, and litigation extended over almost ten years and involved several appeals; in addition, the paying agent did not object to the fee); *Gerald G. Sampson*, 42 Van Natta 1098 (1990) (a 40 percent share of a $275,000 settlement was allowed where the case involved a complex legal issue which initially resulted in a summary judgment against claimant, and settlement was reached only after successful appeal to the Ninth Circuit Court of Appeals, certification of a legal question to the Oregon Supreme Court, and withdrawal of the certification question following a favorable Court of Appeals decision; in addition, the paying agent did not object to the fee); *John P. Christensen*, 38 Van Natta 613 (1986) (claimant's counsel was awarded 50 percent of proceeds where the case had been litigated over a 10-year period, including two appearances before the Oregon Supreme Court and the paying agency did not object to the fee); *John Galanopoulos*, 35 Van Natta 548 (1983) (an extraordinary fee of 40 percent was allowed where claimant's attorney expended nearly three full months in trial preparation for a five day trial and achieved an extremely favorable result); *Leonard F. Kisor*, 35 Van Natta 282 (1983) (a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee).

We find the circumstances of the present case very similar to those in cases where we have authorized extraordinary attorney fees. Specifically, the issues in this case were complex, especially given the nature of claimant's soft tissue injuries, (which resulted in limited objective findings), claimant's possible contributory negligence, and the need for an accident reconstruction expert due to the low impact nature of the collision. Thus, the case required extensive case preparation, including depositions and other discovery techniques. Furthermore, preparation for the litigation and the litigation itself extended over a period of more than a year and a half. In addition, a jury trial was required and extended over five days.

Moreover, claimant's attorney achieved an extremely favorable result, with the jury returning a verdict for claimant for $271,531.83, the full amount requested. After deducting five percent for claimant's contributory negligence, the total adjusted verdict is $257,955.24. In addition, claimant and his counsel agree to an attorney fee of 40 percent, as represented by the retainer agreement and claimant's affidavit. Finally, Travelers does not object to claimant's counsel's request of a fee of 40 percent of the proceeds.

Under these circumstances, we are persuaded that claimant's counsel is entitled to an attorney fee in excess of one-third of the third party judgment. Accordingly, for the reasons expressed herein, we find that this case constitutes extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Commensurate with the request from claimant's counsel and the agreement between claimant and his counsel, we further hold that the extraordinary attorney fee shall equal 40 percent of the third party judgment proceeds. Consequently, claimant's counsel is directed to retain the aforementioned extraordinary attorney fee from the judgment proceeds.

IT IS SO ORDERED.

In the Matter of the Complying Status of
JAMES ESTEP, Employer
WCB Case No. 96-01711

and, In the Matter of the Compensation of
JAMES D. RILEY, Claimant
WCB Case Nos. 96-10727, 96-04894 & 96-04256
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Dept. of Justice, Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) set aside a Proposed and Final Order that found that James Estep was a noncomplying employer; and (2) directed the SAIF Corporation to cease processing claimant's claim under ORS 656.054. On review, the issues are noncompliance and subjectivity.

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

Claimant contends that James Estep did not satisfy the requirement of being a "non-subject" employer as set forth in ORS 656.027(3)(a)(A). We disagree.

David Larson, who lived on Mr. Estep's premises in July 1995, testified that he would occasionally see other people performing chores around the premises, but to his knowledge, Mr. Estep had never hired an employee. (November 25, 1996 Tr. 146-147, 158). Similarly, Annie Watson, who lived with Mr. Estep, testified that Mr. Estep would hire people for one or two days to perform specific tasks, but had not hired any employees. (November 12, 1997 Tr. 133-135). In addition, although Ms. Watson helped Mr. Estep with some of the business management, she did so because of their personal relationship, and not as an employee. (November 12, 1997 Tr. 131-132, 150). Finally, Roberta Logan, who performed limited duties for Mr. Estep, indicated that although she was occasionally paid by Mr. Estep, she was unaware of any permanent employment at Mr. Estep's stables. (January 8, 1998 Tr. 154-158).

Under these circumstances, we agree with the ALJ's conclusion that Mr. Estep was a non-subject employer.[1]

ORDER

The ALJ's order dated January 27, 1999 is affirmed.

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[1] For purposes of ORS 656.027(3)(a)(B), it must be established that there was another subject worker, other than claimant (who is a casual employee) in order to find that the employer was a subject employer. *See Konell v. Konell*, 48 Or App 551, 558 (1980).

In the Matter of the Compensation of
LURA F. CARTER, Claimant
WCB Case No. 98-07983
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside a *de facto* denial of claimant's right ulnar nerve condition; (2) assessed a penalty for the employer's alleged failure to process her claim; and (3) awarded an assessed attorney fee of $3,600. In its brief, the employer argues that the ALJ erred by determining that it had "waived" appearance by failing to appear at the hearing, and by denying a postponement and continuance for the employer to present evidence. The employer also requests remand to allow it to cross-examine Dr. Laubengayer. On review, the issues are hearing procedure, remand, postponement/continuance, compensability, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant began working for the employer in 1994. (Ex. 1). On June 27, 1996, she injured her right shoulder. (*Id.*) The employer accepted a right rotator cuff tear. (Ex. 1A). Dr. Gargaro performed surgical repair of the rotator cuff. (Ex. 3). She subsequently developed a frozen shoulder and underwent manipulation under anesthesia in June 1997. (*Id.*) In the summer of 1997, claimant developed numbness and tingling of the right hand. (*Id.*)

In December 1997, claimant sought treatment from Dr. Laubengayer for continued right shoulder problems. (Ex. 2). On December 17, 1997, Dr. Laubengayer reported that claimant's right arm was getting weaker and causing her more pain. (*Id.*) Claimant complained that her right hand went numb periodically and felt weak. (*Id.*) Dr. Laubengayer referred claimant to Dr. Hartmann, who performed a nerve conduction study and found that claimant had a mild ulnar nerve lesion at the level of the right elbow. (Ex. 3). Dr. Hartmann concluded that claimant had a mild ulnar palsy at the right elbow. (*Id.*) Dr. Laubengayer agreed that claimant had right ulnar palsy. (Ex. 8).

On May 4, 1998, claimant's attorney requested that the employer accept a right ulnar nerve lesion as part of the accepted claim. (Ex. 4).

On August 10, 1998, Dr. Laubengayer reported that claimant continued to have problems with her right shoulder and left elbow. (Ex. 5). He reported that claimant had been disabled from work because of left elbow problems, which occurred because she was unable to use her right arm at work. (*Id.*)

On October 7, 1998, claimant's attorney signed a request for hearing regarding the employer's *de facto* denial. (Ex. 6). On the same date, claimant's attorney wrote to the employer requesting that it accept claimant's left elbow condition as part of her claim. (Ex. 7).

CONCLUSIONS OF LAW AND OPINION

At the January 5, 1999 hearing, the employer did not appear. Claimant's attorney asserted that the issue was compensability of claimant's right ulnar lesion as either a consequential condition claim of the accepted right shoulder rotator cuff tear or as an occupational disease claim related to overuse.[1] (Tr. 2). The ALJ noted that the employer had apparently waived appearance. (Tr. 3). The ALJ addressed only the consequential condition claim because he found that an occupational disease claim had not been presented to the employer. The ALJ relied on Dr. Laubengayer's opinion and set aside the employer's *de facto* denial of claimant's right ulnar condition.

[1] There was no discussion at hearing about claimant's left elbow claim and the ALJ did not address that issue.

After the hearing, but before the ALJ had issued an order, the employer's attorney wrote to the ALJ on January 30, 1999. The employer's attorney explained that his firm had been given claimant's file the previous day. The employer's attorney said the claim file did not include a request for hearing or a notice of hearing, but he noted that the claim examiner recalled claimant's attorney calling him in December 1998 and saying there was a hearing scheduled in early January 1999. The employer's attorney submitted documents to the ALJ and requested that they be included in the record.

On February 5, 1999, the ALJ responded that, to the extent that the employer's letter constituted a motion to reopen the record, the motion was denied. The ALJ did not see any reason for the carrier's nonappearance at the hearing and was not persuaded the record should be reopened because the employer had failed to timely hire counsel. On February 8, 1999, claimant's attorney wrote to the ALJ objecting to the employer's motion to reopen the record. Claimant's attorney asserted that he had spoken to the insurance carrier's adjuster approximately two weeks before the hearing and told him that a hearing was scheduled.

On review, the employer asserts that neither the employer nor its carrier appeared at the hearing because no request for hearing or notice of hearing was sent to either of them and no attempt was made to contact them on the morning of the hearing. The employer argues that it is a requirement of due process that notice be given before the hearing. The employer asserts that the ALJ erred by not making findings that would support an order of default or a similar order.

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

Here, the employer did not attend the January 5, 1999 hearing. The issue is whether the employer's failure to attend was "unjustified" and, therefore, constitutes a waiver of appearance.

The employer asserts that neither the employer nor its carrier received a request for hearing or notice of hearing. The ALJ did not make any specific findings regarding this issue, although he noted there was no response from the employer concerning claimant's request for hearing.

On May 4, 1998, claimant's attorney requested that the employer accept a right ulnar nerve lesion as part of the accepted claim. (Ex. 4). The employer makes no argument that it did not receive a copy of that letter. On October 7, 1998, claimant's attorney signed a request for hearing concerning a *de facto* denial. (Ex. 6). The request for hearing was received by the Board on October 9, 1998. The hearing request listed the employer and its claim administrator. OAR 438-005-0070 provides, in part, that "[a] copy of the request [for hearing] should be mailed to the insurer, self-insured employer, claimant, or if represented, claimant's counsel." Claimant's cover letter with the request for hearing in the Hearings Division file indicates that a copy was sent to the claim administrator.

OAR 438-006-0020 provides that the "Hearings Division shall, by mail, acknowledge receipt of a request for hearing. Such acknowledgment may include notice of date for an informal prehearing conference pursuant to OAR 438-006-0062 or notice of hearing date." *See* ORS 656.263; 656.283(5). With his brief on review, claimant submitted a copy of the notice of hearing in this case. The employer moves to strike this submission on the basis that it is not part of the record. Although this document was not formally admitted as an exhibit, it is part of the Hearings Division file and, as such, it is part of the record on review. *See Terry L. Vanyi*, 50 Van Natta 1016 n.1 (1998) (motion to strike was denied because the documents and pleadings were already present in the record and did not constitute extra-record evidence). Consequently, we deny the employer's motion to strike claimant's copy of the notice of hearing.

The Hearings Division file indicates that copies of the notice of hearing were mailed on October 16, 1998. The notice of hearing showed the date of hearing as January 5, 1999 and said that copies were mailed to claimant, her attorney, the employer and its claim administrator. There is no evidence that either the employer's or the carrier's copies of the notice of hearing were returned to the Hearings Division as undeliverable. Under these circumstances, we are not persuaded by the employer's argument that neither the request for hearing nor the notice of hearing were mailed or otherwise served

on either the employer or the carrier. The documents in the Hearings Division file indicate that the employer and its carrier were mailed a copy of claimant's request for hearing, as well as a copy of the notice of hearing.

Even if we assume, without deciding, that neither the employer nor its carrier received a copy of the request for hearing, or notice of hearing, there are no rules requiring *receipt* of such notice. OAR 438-005-0070 provides, in part that "[a] copy of the request [for hearing] should be mailed to the insurer, self-insured employer, claimant, or if represented, claimant's counsel." That language indicates that a copy of the request for hearing "should be mailed." ORS 656.283(5) provides that "[a]t least 10 days' prior notice of the time and place of hearing *shall* be given to all parties in interest by mail." (Emphasis supplied). OAR 438-006-0020 provides that "[t]he Hearings Division *shall*, by mail, acknowledge receipt of a request for hearing. Such acknowledgment may include * * * notice of hearing date." (Emphasis supplied). Neither the statute nor the rule requires that a party must "receive" the notice of hearing. Rather, ORS 656.283(5) and OAR 438-006-0020 require *mailing* of the notice of hearing to the parties. The notice of hearing in this case indicates that copies were issued and mailed to the parties.[2]

For each of the foregoing reasons, we find that the employer/carrier's failure to appear at the hearing was unjustified. Consequently, we agree with the ALJ that the employer/carrier's unjustified failure to appear at the hearing constitutes a "waiver of appearance" pursuant to OAR 438-006-0071.

Next, the employer argues that the ALJ erred by denying a postponement or continuance or an opportunity for the employer to present evidence. We disagree.

OAR 438-006-0071(2) provides that an ALJ shall dismiss a hearing request if the party that has "waived" appearance is the party that requested the hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. Thus, the rule only contemplates the possibility of postponement or continuance for the party that requested the hearing. *Richard R. Merriman*, 50 Van Natta 2371, 2373 (1998). Because the employer is not the party that requested the hearing in this matter, no postponement or continuance option is available to the employer. *Id.*

The employer argues that claimant failed to establish an occupational disease claim and the ALJ erred by finding that no such claim could be presented, rather than finding a failure of proof. The employer contends that the ALJ should have granted a continuance on his own motion to allow time to run for acceptance or denial of the occupational disease claim presented by claimant at hearing.

At hearing, claimant's attorney asserted that the issue was compensability of claimant's right ulnar lesion as either a consequential condition of the accepted right shoulder rotator cuff tear or as an occupational disease claim related to overuse. (Tr. 2). The ALJ found that the record did not reflect that an occupational disease claim had been presented to the carrier and, therefore, the ALJ "limited claimant's proof" to one of a consequential condition.

On May 4, 1998, claimant's attorney requested that the employer accept a right ulnar nerve lesion as part of the accepted claim. (Ex. 4). Claimant's attorney indicated that the employer would have 30 days to accept or deny the claim. *See* ORS 656.262(6)(d). There is no evidence that claimant submitted an occupational disease claim to the employer before the hearing. Although parties may litigate an issue by implicit agreement, there is no evidence that the employer agreed to litigate the claim under an occupational disease theory.

The employer contends, however, that the ALJ should have accepted the making of the occupational disease claim and should have followed the rule requiring mandatory joinder and continuance due to lack of ten days notice on the new claim. OAR 438-006-0065(1) provides that an ALJ "shall consolidate into one proceeding all cases in which a claimant has requested hearings involving

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[2] Although mailing of the request for hearing and notice of hearing is sufficient, we note that the employer had actual notice of the scheduled hearing. Both the employer and claimant acknowledged that claimant's attorney had spoken to the carrier's claim examiner/adjuster before the hearing and provided notice that a hearing was scheduled. In a January 30, 1999 letter to the ALJ, the employer's attorney said that "[t]he claim examiner does recall claimant's attorney calling him in December 1998, and saying there was a hearing scheduled in early January 1999." Likewise, in a February 8, 1999 letter to the ALJ, claimant's attorney asserted that he had spoken to the "insurance carrier's adjuster" approximately two weeks before the hearing and told him that a hearing was scheduled.

denials of responsibility for a claim issued by insurers or self-insured employers under ORS 656.308(2)(a)." This case does not involve a denial of responsibility. Moreover, claimant has filed a request for hearing only for the *de facto* denial of his request that the employer accept a right ulnar nerve lesion as part of the accepted claim. There has been no denial, *de facto* or otherwise, of an occupational disease claim. We are not persuaded that the ALJ was required to join the claims and grant a continuance. We agree with the ALJ's disposition of the occupational disease claim.

Remand

Alternatively, the employer requests remand to allow it to cross-examine Dr. Laubengayer and rebut that evidence. With its brief, the employer includes a concurrence letter from the employer's attorney signed by Dr. Laubengayer on March 30, 1999. The employer contends that Dr. Laubengayer did not believe claimant's right elbow problem was compensable.

Claimant moves to strike the attached exhibit and argues that, because the employer waived its appearance at the hearing, it may not attempt to reopen the record to offer new evidence. In response, the employer said it was not offering the letter as an exhibit. Rather, the employer asserts that it has simply shown that Dr. Laubengayer has "reversed his mistaken testimony," which supports its motion to remand. (Employer's reply brief at 2).

The exhibit attached to the employer's brief was not admitted at hearing. We have no authority to consider newly discovered evidence. *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1985). Nevertheless, under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. 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).

Dr. Laubengayer's letter signed on March 30, 1999 was not "available" at the time of the January 5, 1999 hearing. That 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 Supreme 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 also Thomas G. Dobson*, 51 Van Natta 297 (1999); *James E. Gore*, 45 Van Natta 1652 (1993) ("evidence is not newly discovered merely because it was generated after the hearing.").

Here, claimant injured her right shoulder on June 27, 1996. (Ex. 1). The employer accepted a right rotator cuff tear. (Ex. 1A). In December 1997, claimant sought treatment from Dr. Laubengayer for continued right shoulder problems. (Ex. 2). She was subsequently diagnosed with a mild ulnar palsy at the right elbow. (Ex. 3). On May 4, 1998, claimant's attorney requested that the employer accept a right ulnar nerve lesion as part of the accepted claim. (Ex. 4). The employer did not respond and claimant filed a request for hearing in October 1998. (Ex. 6). A hearing was held on January 5, 1999 and the record closed on that date. The record included reports from Drs. Laubengayer and Hartmann. After the ALJ issued the Opinion and Order, the employer wrote to Dr. Laubengayer in March 1999 seeking his opinion on causation of claimant's right elbow problem. Dr. Laubengayer responded on March 30, 1999.

Although Dr. Laubengayer's March 30, 1999 report was not available at the time of hearing, we are not persuaded that the information in the report was unobtainable with the exercise of due diligence at the time of hearing. The employer did not appear at hearing, present additional medical evidence at that time, or request that the record be left open for the purpose of obtaining such a report from Dr. Laubengayer or another physician. Under these circumstances, although Dr. Laubengayer's March 30, 1999 report was not available at the time of hearing, we find that the substance of that opinion was obtainable with due diligence at the time of hearing. *See Compton v. Weyerhaeuser Co.*, 301 Or at 648; *Thomas G. Dobson*, 51 Van Natta at 297. For these reasons, we deny the employer's request for remand.

The employer also argues that none of claimant's exhibits were sent timely or received by the employer/carrier before the hearing. The employer contends that "OAR 438-009-0018(4)"[3] requires the ALJ to make a determination of whether new exhibits cause material prejudice and therefore require a continuance of the hearing. According to the employer, the report signed by Dr. Laubengayer on January 3, 1999 (Exhibit 8) caused material prejudice. Because the employer waived its appearance at hearing and did not object to the admission of Exhibit 8 at that time, we do not address this issue for the first time on review. *See Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997); *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

Merits

In light of our conclusion that the employer's failure to attend the hearing was unjustified, we find that the ALJ correctly proceeded to decide the merits of the issues raised by claimant. For the following reasons, we agree with the ALJ that claimant has established a compensable consequential condition.

Because of the multiple possible causes of claimant's right ulnar condition, 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). To establish compensability of the right ulnar condition as a consequential condition, claimant must prove that the accepted right rotator cuff tear is the major contributing cause of the right ulnar condition. *See* ORS 656.005(7)(a)(A).

Claimant injured her right shoulder on June 27, 1996, and the employer accepted a right rotator cuff tear. (Exs. 1, 1A). Dr. Gargaro performed surgical repair of the rotator cuff. (Ex. 3). Claimant subsequently developed a frozen shoulder and underwent manipulation under anesthesia in June 1997. (*Id.*) In the summer of 1997, claimant developed numbness and tingling of the right hand. (*Id.*) In December 1997, claimant sought treatment from Dr. Laubengayer for continued right shoulder problems. (Ex. 2-1). On December 17, 1997, Dr. Laubengayer reported that claimant's right arm was getting weaker and causing her more pain. (*Id.*) Claimant complained that her right hand went numb periodically and felt weak. (*Id.*) Dr. Laubengayer referred claimant to Dr. Hartmann, who performed a nerve conduction study and determined that claimant had a mild ulnar nerve lesion at the level of the right elbow. (Ex. 3). Dr. Laubengayer agreed with Dr. Hartmann's conclusion that claimant had right ulnar palsy. (Exs. 3, 8-1).

As claimant's treating physician, we find no reasons not to rely on the opinion of Dr. Laubengayer. *See Weiland v. SAIF*, 64 Or App 810 (1983). Before claimant had been examined by Dr. Hartmann, Dr. Laubengayer reported that claimant's shoulder pain was "probably related to her shoulder surgery and problems and the nerve problem is probably separate but I cannot be absolutely certain." (Ex. 2-2). In a later concurrence letter from claimant's attorney, Dr. Laubengayer agreed that claimant's right ulnar palsy was "in major part caused by the right shoulder injury and then subsequent continued repetitive motions of her work activities." (Ex. 8). Dr. Laubengayer agreed that the "right shoulder injury required [claimant] to exert more movement of her forearm and elbow to compensate for the right shoulder injury, and this explains how the right ulnar palsy developed as a consequence of the initial right shoulder injury." (*Id.*)

Although Dr. Laubengayer initially felt claimant's "nerve problem" was separate from claimant's shoulder surgery, he subsequently related the right ulnar palsy, in major part, to her right shoulder *injury* and her continued repetitive work activities. To the extent that Dr. Laubengayer's later medical opinion differed from his earlier comment on causation, we find his change of opinion to be reasonable. *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). His initial comment referred to claimant's surgery, rather than the shoulder injury in general. Furthermore, Dr. Laubengayer's later opinion was offered after claimant had been examined and tested by Dr. Hartmann. Based on Dr. Laubengayer's opinion, we conclude that claimant has established compensability of her right ulnar palsy as a consequential condition.

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[3] We presume the employer is referring to OAR 438-007-0018(4).

Penalties

At hearing, claimant sought penalties for the employer's allegedly unreasonable denial and failure to process the request for claim acceptance in a timely manner. (Tr. 3). The ALJ found there was no explanation for the carrier's failure to process claimant's request for acceptance of the consequential condition and assessed a penalty against the employer.

On review, the employer argues that the ALJ erred in assessing penalties when there was never any medical report submitted to the employer or carrier in support of the claim before the hearing.

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).

On May 4, 1998, claimant's attorney requested that the employer accept a right ulnar nerve lesion as part of the accepted claim. (Ex. 4). The employer makes no argument on review that it did not receive claimant's May 4, 1998 request. This letter triggered the employer's duty to issue a formal, written acceptance or denial of that condition within 30 days. *See* ORS 656.262(6)(d). The employer's failure to comply with the statute was unreasonable and we agree with the ALJ that the employer failed to properly process the claim. We conclude that the employer unreasonably delayed processing the claim and we affirm the ALJ's assessment of a penalty.

Attorney Fees

The employer contends that the ALJ's attorney fee award of $3,600 for services at hearing is excessive, particularly because the employer did not appear and actively resist the claim.

We determine the amount of claimant's counsel's attorney fee for services at hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issue in dispute was compensability of claimant's right ulnar condition. Thirteen exhibits were received into evidence, all of which were submitted by claimant's counsel. There were no depositions. The hearing lasted 45 minutes and the transcript consists of 30 pages. Claimant testified on his own behalf. Claimant's counsel did not submit a statement of services or an affidavit describing counsel's time expenditures.

As compared to typical compensability cases, the issue here was of below average complexity. We note that the employer did not appear at hearing or actively resist the claim. The claim's value and the benefits secured were of average proportions. The hearing was not lengthy, lasting only 45 minutes. Finally, there was a risk that claimant's counsel's efforts might have gone uncompensated if the ALJ had determined that Dr. Laubengayer's opinion was insufficient to establish compensability.

After considering these factors, we consider the ALJ's $3,600 award to be excessive. Specifically, after consideration of the aforementioned factors, we conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. In particular, we have considered the complexity of the issue, the value of the interest involved, the nature of the proceeding and the risk that claimant's counsel might go uncompensated.

Finally, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services concerning the attorney fee or penalty issues. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 5, 1999 is affirmed in part and modified in part. The ALJ's attorney fee award is modified to $3,000. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $750, payable by the employer.

In the Matter of the Compensation of
NATHANIEL E. NASH, Claimant
WCB Case Nos. 98-00457, 97-09779, 97-04938 & 97-04937
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
William J. Blitz, Defense Attorney

Reviewed by Board Members Biehl and Bock.

Self-Insured Management Services (SIMS), on behalf of the self-insured employer, Barrett Business Services (Barrett), requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its compensability denial of claimant's abdominal injury claim; (2) set aside its compensability and responsibility denial of claimant's occupational disease claim for a right upper extremity condition; and (3) upheld the SAIF Corporation's responsibility denial of the right upper extremity condition, issued on behalf of Industrial Finishes. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following modification/ supplementation of the ALJ's responsibility analysis concerning claimant's right upper extremity condition.

The ALJ set aside SIMS' responsibility denial of claimant's right upper extremity condition, finding that claimant's work activities for Barrett were the "sole cause" of the disputed condition. On review, SIMS contends that the ALJ should have assigned responsibility to SAIF because claimant first sought medical treatment after beginning work activities for SAIF's insured. We disagree.

SIMS is correct that claimant first sought treatment for his right upper extremity condition while working for SAIF's insured (which followed his employment with Barrett). (Exs. 3, 13-2). Therefore, SAIF 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). A carrier that otherwise would be responsible under the last injurious exposure rule may avoid responsibility, however, if it proves either: (1) that it was impossible for conditions at its workplace to have caused the disease; 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).

Here, we agree with the the ALJ's reasoning that the persuasive medical opinions from Drs. Wilson, Brooks and Podemski establish that claimant's employment at Barrett was the sole cause of his right upper extremity condition. We, therefore, conclude that the ALJ correctly determined that responsibility for claimant's right upper extremity condition rests with SIMS/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 regarding the compensability issue is $1,000, payable by SIMS, on behalf of Barrett Business Services. 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 January 19, 1998 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SIMS, on behalf of Barrett Business Services.

In the Matter of the Compensation of
RICHARD J. RIVERA, Claimant
WCB Case No. 95-04359
ORDER ON REMAND
Victor Calzaretta, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Rivera v. City of Gresham*, 157 Or App 199 (1998). The court reversed our order in *Richard J. Rivera*, 49 Van Natta 1592 (1997), that upheld a denial of claimant's mental disorder claim for post traumatic stress disorder (PTSD). In reaching our conclusion, we adopted that portion of the Administrative Law Judge's (ALJ's) order that had referred to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed 1994)(DSM IV) and determined that PTSD could not be diagnosed unless all of the criteria contained in DSM IV were satisfied. The court held that we erred in holding that each of the DSM-IV diagnostic criteria must be satisfied to establish that claimant suffered from PTSD. Because it was not possible for the court to determine whether the result would have been different had we not, in effect, made our own diagnosis of claimant's condition on the basis of our reading of the DSM-IV, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established that the January 4, 1984 shooting incident was the major contributing cause of a mental disorder. We agree, but do so based on the following reasoning.

To establish the compensability of a stress-related mental condition, claimant must prove that the employment conditions were the major contributing cause of his disease. ORS 656.802(2)(a). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer or cessation or employment or employment decisions attendant upon ordinary business or financial cycles. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

As noted by the ALJ, the parties do not dispute that the alleged work stressor existed in the real and objective sense. (O & O at p. 6). In addition, the parties do not dispute that the work stressor was not generally inherent or related to job performance. (Id.). Rather, the disputed issues are whether claimant has a mental disorder that is recognized by the medical community and whether claimant established the requisite causal relationship between the 1984 shooting incident and his alleged condition.

The ALJ found that claimant was not a credible witness, based on his demeanor at hearing, and the substance of his testimony. We agree with and adopt the ALJ's conclusion concerning claimant's credibility with the following supplementation.

Claimant testified that he had experienced nightmares "many times a month" or at least "once a week" since the 1984 shooting incident. (Day 2 Tr. 198, 216). However, claimant did not seek any psychological or counseling treatment until December 1994 when he first saw Dr. Artwohl. (Ex. 63). Moreover, claimant's testimony was not consistent with the testimony of his wife, who indicated that claimant would occasionally experience nightmares but at a frequency of less than once a month. (Day 1 Tr. 158). In addition, Dr. Artwohl's initial evaluation indicated that claimant was under stress as a result of the December 1994 internal affairs investigation. (Ex. 43-2). However, claimant testified that he was only mildly upset by the pending investigation and that the investigation was not related to him seeking treatment from Dr. Artwohl some twenty days later. (Day 3 Tr. 49).

Although not statutorily required, the Board generally defers to the ALJ's credibility determination. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). Because the ALJ's credibility finding was based upon the observation of claimant's demeanor, and given our agreement concerning the substance of claimant's testimony, we defer to that determination. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990).

Because the medical opinions that support claimant (Dr. Artwohl and Dr. Fredrickson) are based on claimant's history, those opinions are not persuasive. *See Miller v. Granite Construction Co.*, 77 Or App 473, 476 (1977). Because we are not persuaded by the opinions of Drs. Artwohl and Dr. Fredrickson, and in light of the contrary opinions from Drs. Glass and Davies, claimant has not established, by clear and convincing evidence, that the 1984 work incident was the major contributing cause of his claimed condition.[1] Accordingly, the self-insured employer's denial must be upheld.

ORDER

The ALJ's order dated March 21, 1997 is affirmed.

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[1] Inasmuch as claimant has not established the requisite causal relationship, we do not reach the issue of whether claimant suffers from PTSD.

In the Matter of the Compensation of
JASON J. DENAKIS, Claimant
WCB Case No. 98-02447
ORDER ON REVIEW
James E. Dodge, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's L5-S1 disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue (compensability of a L5-S1 disc protrusion), and the value of the interest involved.

ORDER

The ALJ's order dated February 25, 1999 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
SANDRA A. HARSEN, Claimant
WCB Case No. 98-07414
ORDER ON REVIEW
Robert Laird, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's 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 deny SAIF's request for remand, and adopt and affirm the ALJ's order with the following supplementation.

Claimant requested a hearing challenging SAIF's denial of her occupational disease claim for right upper extremity conditions. The ALJ found that claimant had established compensability and directed SAIF to accept and process the right upper extremity conditions of shoulder AC joint strain, supraspinatus tendinitis, elbow epicondylitis and wrist tendinitis. The ALJ also awarded 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 erred by failing to make specific findings of fact regarding each factor of OAR 438-015-0010(4) in awarding the assessed attorney fee. 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). 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 OAR 438-015-0010(4) and identified the factors he considered in determining the fee. The ALJ explained that, in awarding the $3,000 fee, he considered the average time devoted to the case (as represented by the record), the average complexity of the issue, the average value of the interest involved and benefits obtained, and the significant risk that claimant's attorney's efforts might have gone 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); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).

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 regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated March 10, 1999 is affirmed.

In the Matter of the Compensation of
MARK E. LANDON, Claimant
WCB Case No. 98-02810
ORDER OF DISMISSAL
Bryant, Emerson, et al, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

Claimant has requested Board review of Administrative Law Judge (ALJ) Marshall's May 13, 1999 order that upheld the self-insured employer's denial of claimant's left leg injury claim. The employer moves to dismiss the request for review on the basis that it was not timely filed. We dismiss.

FINDINGS OF FACT

On May 18, 1998, the ALJ issued an Opinion and Order upholding the employer's denial of claimant's left leg injury claim. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for Board review must be mailed to the Board and to the other parties to the proceeding within the 30-day appeal period.

On June 21, 1999, the Board received a letter dated June 14, 1999 from claimant's attorney requesting Board review of the ALJ's order.

On June 22, 1999, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for review.

On June 25, 1999, the Board received the employer's motion to dismiss the request for review, asserting that the request was not timely filed.

CONCLUSIONS OF LAW AND OPINION

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

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

Here, the 30th day after the ALJ's May 13, 1999 order was Saturday, June 12, 1999. The final day to perfect a timely appeal was Monday, June 14, 1999, the first business day following the expiration of the 30-day period. *See Anita L. Clifton*, 43 Van Natta 1921 (1991).

Claimant's request for review was not mailed by registered or certified mail and it was received on June 21, 1999, after the expiration of the 30-day appeal period. Thus, we presume that the request for review is untimely unless claimant can show to the contrary.

Because we find that claimant did not timely file the request for review with the Board or other parties, we lack jurisdiction to review the ALJ's order. *See* ORS 656.289(3). Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
SECO O. CASARES, Claimant
WCB Case No. 98-02961
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) declined to award temporary partial disability (TPD) from August 29, 1997 through January 12, 1998; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay TPD during this period. On review, the issues are rate of temporary partial disability and penalties.

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

Although conceding that claimant was partially disabled from August 29, 1997 to January 12, 1998, SAIF contended at hearing that claimant's TPD rate was "zero" because claimant was working during that period and his wages were not known. The ALJ found that claimant had presented no evidence regarding his rate of pay or normal working hours during the period in dispute. Concluding that claimant had the burden of proving that his rate of TPD was incorrect, the ALJ found that claimant had not established that his TPD rate was other than "zero." *See* ORS 656.266. Thus, the ALJ declined to order payment of TPD.

On review, citing ORS 656.262(1), claimant contends that it was SAIF's obligation to determine the appropriate rate of temporary disability.[1] Claimant requests that we order SAIF to process the claim in accordance with ORS 656.262(1) and "to determine the precise value of the time loss entitlement from August 29, 1997 through January 12, 1998." For the following reasons, we affirm the ALJ's order.

We agree with claimant that SAIF has the responsibility to process the compensable claim under ORS 656.262(1). On the other hand, claimant has the burden of proving that SAIF incorrectly calculated the rate of TPD as "zero." *See Coombe v. SAIF*, 111 Or App 71, 75 (1992); *Oscar J. Myers*, 48 Van Natta 1283, 1284 (1996).

Here, there is no dispute that claimant worked during the period in dispute. Claimant, however, presented no evidence that the wages earned at modified employment were less than the "at-injury" wages. *See* ORS 656.212(2); *Lonnie L. Dysinger*, 47 Van Natta 2282, 2283 (1995). In fact, SAIF twice requested earnings information from claimant, but received no response. (Exs. 18A, 37A). In addition, claimant presented no wage information at hearing to contradict SAIF's calculation of TPD. Under these circumstances, we agree with the ALJ that claimant failed to sustain his burden of proving that SAIF incorrectly calculated his TPD rate.[2]

ORDER

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

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[1] ORS 656.262(1) makes the insurer or self-insured employer responsible for "[p]rocessing of claims and providing compensation for a worker."

[2] The dissent alleges that SAIF unilaterally terminated temporary disability. Because this dispute concerns claimant's entitlement to temporary disability upon claim closure, the issue is claimant's entitlement to substantive, rather than procedural, temporary disability. *See Dorothy E. Bruce*, 48 Van Natta 518 (1996). Therefore, the unilateral termination issue the dissent raises is not relevant.

Board Chair Bock specially concurring.

I agree with the majority that claimant failed to sustain his burden of proving that SAIF incorrectly calculated his temporary partial disability (TPD) rate. I write separately, however, in order to express my views regarding the obligations of carriers and claimants in the workers' compensation system.

The dissent correctly notes that, pursuant to ORS 656.262(1), a carrier has an obligation to process a claim. While SAIF's claim processing in this case was less than stellar, the dissent overlooks the fact that the workers' compensation system imposes obligations on *both* carriers *and* claimants. For instance, ORS 656.262(14) requires that claimants cooperate and assist carriers in the investigation of a claim. Moreover, that statute also requires that injured workers submit to personal and telephonic interviews and other formal and informal information gathering techniques.

My review of the overall statutory scheme persuades me that the workers' compensation system is a compromise between the competing interests of injured workers and carriers that requires both sides to do their part in ensuring that claims are properly and efficiently processed. In light of these observations, I am troubled by claimant's failure to respond on two occasions to reasonable requests from SAIF for wage earnings information. Not only did claimant fail to respond on those occasions, but he also failed to provide any evidence on the earnings issue when afforded yet another opportunity at hearing.

Under these circumstances, I agree with the majority and the ALJ that claimant failed to sustain his burden of proving that his TPD rate was other than "zero." Therefore, I specially concur in the result.

Board Member Phillips Polich dissenting.

The majority refuses claimant's request that we order SAIF to precisely determine the rate of temporary disability from August 29, 1997 through January 12, 1998. Because, I would grant claimant's reasonable request, I dissent. I reason as follows.

First, SAIF unilaterally terminated temporary disability on August 29, 1997 and did not process claimant's entitlement to temporary partial disability (TPD) until *after* the April 20, 1998 Notice of Closure issued. Under ORS 656.262(1), SAIF's obligation to properly process the claim existed prior to this time. There is no evidence that SAIF ever engaged in any attempt to calculate whether TPD was owed, let alone any specific rate. Under these circumstances, it is unfair to claimant to infer that SAIF actually made a temporary disability calculation and that the rate was zero.

Second, the cases the majority cites, *Coombe v. SAIF*, 111 Or App 71 (1992); *Oscar J. Myers*, 48 Van Nattta 1283 (1996), do state that the claimant failed to meet his burden of proof. However, those cases differ considerably from this case factually and never focused on the merits of the burden of proof issue. Moreover, in each case, the carrier correctly applied an administrative rule and the claimant in each case did not take the next step in meeting his burden of proof. This case is different in that, unlike those cases, the carrier here did not properly process the claim.

The unfortunate precedent that the majority establishes in this case is that a carrier can fail to determine the correct rate of TPD and then it becomes a claimant's burden to show the correct rate of TPD. This is not how the workers' compensation system was designed. The carrier has the burden to process a claim. ORS 656.262(1). The majority undermines that statutory principle through its decision to affirm the ALJ's order. To me, it is far more logical to require the carrier to perform its claim processing obligation under ORS 656.262(1) and make an affirmative temporary disability calculation. Once that is done, then claimant would have the burden to show that the calculation was incorrectly made.

Finally, the majority concludes that there is no evidence that the wages earned at modified employment were less than the at-injury wages. Just as fairly, the record could be described as having no evidence that the wages earned at modified employment were any different after August 29, 1997 than they were before.

Because I am troubled by the majority's analysis and by the precedent that our decision sets, I must part company with the majority. Accordingly, I dissent.

In the Matter of the Compensation of
KENNETH F. PLUMBER, Claimant
WCB Case No. 98-07991
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) determined that it "waived" appearance by failing to appear at the hearing; (2) directed the employer to pay temporary total disability from May 21, 1998 through May 31, 1998; (3) directed the employer to pay temporary total disability from September 1, 1998 until termination according to law; (4) assessed a 25 percent penalty for the employer's allegedly unreasonable claim processing; (5) directed the employer to pay a 25 percent penalty pursuant to the September 23, 1998 Stipulation and Order of Dismissal; (6) set aside its "de facto" denial of claimant's claim for herniated discs at L4-5 and L5-S1; and (7) awarded claimant's attorney a fee of $9,375 for his services in setting aside the denial. In support of a motion for remand, the employer has submitted "post-hearing" documentary evidence pertaining to the reasons for its failure to appear at hearing and to the merits of the temporary disability and compensability issues. On review, the issues are remand, hearing procedure, temporary disability, compensability, penalties and attorney fees. We deny the motion for remand, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the pertinent facts. Claimant sustained a compensable injury in June 1997, accepted as a disabling lumbar strain. An August 1997 MRI revealed degenerative changes and disc prolapses at L4-5 and L5-S1. In December 1997, claimant began treating conservatively with Dr. Nash, neurosurgeon. Claimant continued to experience significant low back pain. Nash took claimant off work on May 21, 1998. On June 1, 1998, Nash requested authorization to perform a lumbar laminectomy. He performed the surgery on July 1, 1998.

Meanwhile, the employer had not responded to claimant's attorney's requests for discovery. As a result, claimant filed a May 28, 1998 request for a civil penalty with the Department. On June 5, 1998, claimant filed a Request for Hearing with the Board's Hearings Division, raising issues of: (1) entitlement to temporary total disability; (2) penalties and attorney fees; (3) entitlement to reimbursement for prescription medications; and (4) entitlement to discovery. The matter was assigned WCB Case No. 98-04441.

Pursuant to a September 23, 1998 Settlement Stipulation and Order of Dismissal, claimant agreed to withdraw his request for sanctions before the Department and dismissal of his hearing request with the Board's Hearings Division in exchange for the employer agreeing to:

> (1) "reinstate temporary disability as of June 1, 1998 and continue temporary disability until it can be terminated pursuant to ORS 656.268(3) or until employer issues a denial for the herniated discs at L5-S1 and L4-5";
>
> (2) "pay a penalty equal to 25 percent of all temporary disability due from June 1, 1998 through August 31, 1998";
>
> (3) "within 30 days from the date this settlement is approved by an Administrative Law Judge ("ALJ") employer shall accept or deny herniated discs at L5-S1 and L4-5." (Numbering added.)

The parties further agreed that claimant "reserves the right to claim entitlement to temporary disability from May 21, 1998 through May 31, 1998." The settlement was approved by an ALJ on September 23, 1998.

The employer did not accept or deny the claim within 30 days of the approved settlement or pay the 25 percent penalty on the temporary disability due from June 1, 1998 through August 31, 1998.

On October 8, 1998, claimant filed the Request for Hearing in this case, raising the issues of enforcement of the September 23, 1998 Stipulation, temporary disability from September 1, 1998, and penalties and attorney fees. The Request for Hearing was copied to the employer and AIG, its claim processing agent. On October 19, 1998 a Notice of Hearing (announcing a January 6, 1999 hearing) was mailed to both the employer and AIG. Neither the employer's nor AIG's copies of this Notice of Hearing were returned to the Hearings Division as undeliverable. On December 29, 1998, claimant supplemented his hearing request to add the issue of "de facto" denial of lumbar surgery. The supplemental hearing request was copied to the employer and AIG.

A hearing was convened on January 6, 1999. Claimant and his counsel were present, but neither the employer nor AIG appeared at the hearing. The ALJ found that the employer had "waived" appearance under OAR 438-006-0071(2) and proceeded to determine the merits of the enforcement request, temporary disability, compensability, penalty and attorney fee issues.

Relying on the opinion of Dr. Nash, claimant's attending physician, the ALJ held that claimant was entitled to temporary total disability benefits from May 21, 1998 through May 31, 1998, and from September 1, 1998 until termination is authorized by law. The ALJ also determined that the employer unreasonably refused to pay each period of temporary disability and assessed a penalty of 25 percent of each period of temporary total disability compensation ordered. The ALJ further ordered the employer to pay claimant the penalty equal to 25 percent of the temporary total disability compensation that it agreed to pay in the September 23, 1998 Stipulation (for the period June 1, 1998 through August 31, 1998). In addition, again relying on the unrebutted opinion of Dr. Nash, the ALJ concluded that claimant's L4-5 and L5-S1 disc herniations were compensable. Finally, the ALJ awarded an attorney fee of $9,375 for claimant's attorney's services at hearing regarding the compensability issue.

On March 4, 1999, the attorney who represented the employer at the time of the September 23, 1998 Stipulation requested reconsideration of the ALJ's order, asserting that he had not received notice of either of claimant's requests for hearing, and requesting that the record be reopened to allow presentation of the employer's defenses and evidence. After considering the parties' arguments concerning the employer's failure to appear, the ALJ issued a March 17, 1999 Order on Reconsideration that republished the February 4, 1999 Opinion and Order in its entirety. The employer submitted a Second Motion for Reconsideration, and, on March 25, 1999, the ALJ issued an order denying the motion.

On review, the employer moves for remand to the ALJ for consideration of "post-hearing" documentary evidence. Alternatively, if the motion for remand is not granted, the employer asserts that claimant failed to prove entitlement to temporary disability or compensability based on the record developed before the ALJ. For the following reasons, we deny the motion for remand, reverse the penalty assessed on the employer's allegedly unreasonable refusal to pay temporary total disability from May 21, 1998 through May 31, 1998, and agree with the ALJ's determination of the remaining issues.

Waiver of Appearance

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

In this case, the employer failed to attend the January 6, 1999 hearing. The issue, therefore, is whether that failure to attend was "unjustified" and thus constitutes a waiver of appearance. The employer's basis for requesting that the record be reopened is that AIG, the claims processing agent for the employer, and the employer's attorney did not receive copies of the Notice of Hearing, and that claimant's attorney failed to provide the employer's counsel with copies of his requests for hearing or copies of exhibits or their cover letter. The employer has submitted as part of its motion for remand affidavits dated May 5, 1999 from AIG's claims representative, Ms. Hunsperger, and from the employer's counsel, Mr. Brenneman.

Ms. Hunsperger states that AIG did not receive a copy of the Notice setting the hearing for January 6, 1999. Ms. Hunsperger also states that she first learned of the January 6, 1999 hearing on January 20, 1999, when she received a January 18, 1999 letter from claimant's attorney forwarding to her his January 5, 1999 letter to the ALJ, which had not previously been copied to her.

Mr. Brenneman states that he had no notice of the January 6, 1999 hearing. Brenneman also states that he made no representation to claimant's attorney that after the September 23, 1998 Settlement Stipulation any further correspondence would be with the claims adjuster at AIG rather than his office. Brenneman also states that claimant brought exhibits to the hearing rather than sending them to the employer or himself in a timely manner as required under the rules, and that claimant's exhibit list, dated January 5, 1999, does not show that it had been copied to the employer or AIG.[1]

Based on the circumstances existing at the time the ALJ determined that the employer's failure to appear was unjustified, we agree that the employer had "waived" appearance at the hearing. Obviously, the ALJ did not have knowledge of the alleged justification that the employer has now submitted. Because our review of the record is limited to that developed before the ALJ, we must determine whether a remand is necessary for consideration of the employer's affidavits.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

In this case, we find no compelling reason to remand for consideration of the information contained in the "post-ALJ order" affidavits. Specifically, we conclude it is not reasonably likely to affect the outcome of the case because the justifications contained in the affidavits are not sufficient to excuse the employer's failure to appear at the hearing. We find that the Notice of Hearing was mailed on October 19, 1998 to the last known addresses of the employer and AIG. There was no contention by the employer that these addresses were inaccurate, and the Notices of Hearing had not been returned to the Hearings Division by the postal service.[2] Moreover, providing copies to attorneys is not a requirement because counsel is not a "party." *See* ORS 656.005(21); *Haskell Corporation v. Filippi*, 152 Or App 117 (1998); *Charlotte M. Soros*, 50 Van Natta 2072, *on recon* 50 Van Natta 2233 (1998). Therefore, we find that the evidence supporting the employer's motion for remand is unlikely to affect the outcome of the issue of whether its failure at appear at hearing was justified. Thus, we decline to remand to the ALJ for submission of additional evidence on this issue.

Moreover, because the employer's failure to appear at the hearing was unjustified, the ALJ correctly proceeded to determine the merits of the issues raised by claimant based on the record as developed.[3] Therefore, we next address the ALJ's determination that claimant's claim for new medical conditions is compensable and that claimant is entitled to temporary total disability from May 21, 1998 through May 31, 1998, and from September 1, 1998 until termination is authorized by law.

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[1] Claimant asserts that there were no extraordinary circumstances that would justify reopening the record, *i.e.*, a postponement or continuance. Because the employer is not the party that requested the hearing in this matter, no postponement option is available to the employer. *Richard R. Merriman*, 51 Van Natta 167 (1999). Thus, if the employer's failure to attend the hearing was unjustified, the ALJ proceeds to determine the merits of the issues raised by claimant based on the record as developed. If the employer's failure to attend the hearing was justified, we may remand on the basis that the record was insufficiently developed.

[2] Only the employer's counsel and AIG assert that they did not receive the Notice of Hearing. There is no assertion that the employer itself did not receive a copy of the hearing notice.

[3] The employer has submitted "post-order" documentary evidence on the compensablity issue, including a December 10, 1997 medical report from Drs. Reimer and McKillop, and an October 22, 1998 concurrence letter from Dr. McKillop. We interpret the employer's submission as a motion for remand. We deny the motion because we are not persuaded that the proffered evidence was unobtainable with the exercise of due diligence prior to hearing. In other words, but for its unjustified failure to appear at the hearing, the employer could have presented this evidence at the January 6, 1999 hearing.

Compensability - New L5-S1 and L4-5 Herniated Discs

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

Temporary Disability - May 21, 1998 through May 31, 1998 and Related Penalties

The employer argues that claimant never made a claim for temporary total disability for the period from May 21, 1998 through May 31, 1998 and that neither of claimant's requests for hearing raised this issue. Therefore, the employer contends that it should not be penalized for not paying time loss for this period.

The Settlement Stipulation states that claimant "reserves the right to make a claim" for temporary total disability from May 21, 1998 through May 31, 1998. Claimant raised the issue of time loss for this period at hearing. (Tr. 1). Therefore, the issue was properly before the ALJ.

After reviewing the record, we adopt and affirm the ALJ's opinion regarding claimant's entitlement to temporary total disability from May 21, 1998 through May 31, 1998.

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." Because claimant reserved the issue of time loss for this period and did not raise the issue until hearing, we find that the employer did not unreasonably refuse to pay compensation pursuant to the September 23, 1998 Stipulation. Thus, the employer is not subject to a penalty based on this period of temporary disability.

Temporary Total Disability - September 1, 1998 to the Present

We adopt and affirm the ALJ's opinion on claimant's entitlement to temporary total disability for this period, with the following supplementation.

Pursuant to the September 23, 1998 Settlement Stipulation, the parties agreed that the employer "will reinstate temporary disability as of June 1, 1998 and continue temporary disability until it can be terminated pursuant to ORS 656.268(3) *or* until employer issues a denial for the herniated discs at L5-S1 and L4-5." (Emphasis added). The parties further agreed that "within 30 days from the date this settlement is approved by an [ALJ] employer shall accept or deny herniated discs at L5-S1 and L4-5."

Here, the employer did not accept or deny the herniated disc conditions within 30 days of the stipulation. Therefore, according to the agreement between the parties, the employer was obligated to reinstate temporary disability as of June 1, 1998 and continue payment until it can be terminated pursuant to ORS 656.268(3).[4] Claimant testified that the employer paid him a check that included permanent disability payments through August 31, 1998, but nothing thereafter. Based on our *de novo* review of the record, we find no grounds for termination of claimant's temporary disability payments under the statute. The record does not establish that claimant was released for regular work or returned to regular work after September 1, 1998. We also do not find evidence to support termination pursuant to ORS 656.268(3)(d). Therefore, the employer had no authority to discontinue payment of temporary total disability as of September 1, 1998 or thereafter.

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[4] ORS 656.268(3) provides that temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment; or

"(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262 (4) or other provisions of this chapter."

Finally, the employer contends that, once the 30-day deadline to accept or deny the claim had passed, it had "de facto" denied the claim, thereby eliminating its obligation to pay time loss, because compensability of the conditions had to be litigated.[5] We disagree.

The stipulation expressly provides that the employer would continue to make temporary total disability payments until it "issues" a denial. The employer has not issued a denial in this case. *See* ORS 656.262(9).

In sum, there were two grounds under which the employer could terminate temporary total disability pursuant to the stipulation. Here, there is no basis for termination of temporary disability benefits under ORS 656.268(3) *or* by issuance of a denial. Therefore, neither condition precedent to termination of temporary total disability under the stipulation has been satisfied.

Penalty for Failure to Pay Temporary Disability from September 1, 1998

As discussed above, the employer agreed in the September 23, 1998 Stipulation that it would continue to pay temporary disability compensation until it could be terminated pursuant to ORS 656.268(3) or it issued a denial for the herniated discs. The employer did not issue a timely written denial pursuant to the stipulation. Moreover, as previously discussed, none of the grounds set forth in ORS 656.268(3) for termination of temporary total disability occurred. Consequently, we agree with the ALJ that the employer's failure to pay temporary total disability pursuant to the parties' stipulation was unreasonable and that claimant is entitled to a penalty equal to 25 percent of the unpaid temporary total disability due pursuant to the stipulation.

Finally, the employer asserts that there is no authority for the ALJ to award additional penalties for the employer's allegedly unreasonable refusal to pay for prescription medications because all issues of penalties were resolved by the stipulation. The employer misreads the ALJ's order in regard to this matter. The ALJ noted that claimant needed to identify the prescriptions at issue and the date that they were submitted to and received by AIG, as well as the date they were reimbursed, and, without that information, he was unable to determine if there was an unreasonable delay in payment. Accordingly, based on the submitted record, the ALJ denied claimant's request to award a penalty for allegedly late reimbursement of prescription medications.

Attorney Fee

The ALJ awarded an attorney fee of $9,375 for prevailing against the employer's denial. The ALJ considered claimant's counsel's statement of services and the factors in OAR 438-015-0010(4) in awarding the attorney fee.

The employer argues that the attorney fee award of $9,375 is excessive given the efforts expended and the results obtained. For the following reasons, we disagree.

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 new low back conditions were compensable. Seventeen exhibits were received into evidence, all of which were generated and submitted by claimant's counsel. There were no depositions. The January 6, 1999 hearing lasted one hour. The transcript was 19 pages. Claimant testified on his own behalf.

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[5] We note that this assertion does not address the employer's failure to pay temporary total disability pursuant to the stipulation from September 1, 1998 through October 23, 1998, the 30th day after the stipulation was approved.

After the January 6, 1999 hearing, claimant's attorney submitted a two-page letter and a one-page letter regarding the issue of the employer's request for reconsideration. In regard to the January 6, 1999 hearing, claimant's attorney submitted an affidavit stating that he worked 75 hours on the case at an hourly rate of $125, that his assistant worked 15 hours at an hourly rate of $45, and requested a total attorney fee of $10,000. The ALJ awarded an attorney fee of $9,375 for services at the January 6, 1999 hearing. In awarding the fee, the ALJ acknowledged that the 75 hour figure would appear excessive, but that AIG's refusal to process the claim at virtually every step explains the 75 hours that claimant's attorney spent on this case.

Although the medical issues were of average complexity, we agree with the ALJ's conclusion that the proceedings regarding the compensability of claimant's new medical conditions were prolonged. The value of the interest involved and the benefit to claimant are substantial, in that claimant has had surgery for his low back condition, and, potentially, would be entitled to a permanent disability award. Moreover, claimant's attorney and the employer's 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 $9,375 is reasonable in this case for claimant's counsel's services at the hearings level.

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 and temporary disability issues is $1,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to those issues (as represented by claimant's respondent's brief), the complexity of the issues, and the values of the interests involved.[6]

ORDER

The ALJ's order dated February 4, 1999, as reconsidered on March 17, 1999, is reversed in part and affirmed in part. That portion of the order assessing a penalty based on the temporary total disability due from May 21, 1998 through May 31, 1998 is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $1,500, to be paid by the employer.

[6] Claimant's attorney is not entitled to an attorney fee for services devoted to the penalty and attorney fee issues on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Saxton v. SAIF*, 80 Or App 631 (1986).

In the Matter of the Compensation of
RONALD E. ROGERS, Claimant
WCB Case Nos. 95-01825, 94-14661 & 93-11544
SECOND ORDER ON REMAND
Pozzi, Wilson & Atchison, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Cobb & Woodworth, Defense Attorneys

Liberty Northwest Insurance Corporation (Liberty Northwest) requests reconsideration of our June 14, 1999 Order on Remand that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld Cigna Insurance Company's (Cigna's) denial for the same condition. Specifically, Liberty Northwest contends that claimant's right shoulder condition worsened after 1985, when Cigna came on the risk, and therefore asserts that Cigna should be responsible for claimant's right shoulder condition.

After considering Liberty Northwest's motion, and memorandum in support, we have nothing further to add to our prior order. Accordingly, our June 14, 1999 Order is withdrawn. On reconsideration, we adhere to and republish our June 14, 1999 Order on Remand.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID D. YARMER, Claimant
WCB Case No. 98-05910
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral hearing loss. On review, the issue is compensability.

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

The parties agree that claimant has sensorineural high-frequency hearing loss. Medical opinions regarding causation were provided by otolaryngologists Dr. Hodgson for the employer and Dr. Lipman for claimant. Both doctors identified seven potential causes of hearing loss: (1) loud noise at work; (2) loud noise off the job; (3) viral illness; (4) heredity; (5) head injury; (6) presbycusis (a function of age); and (7) certain medications.

After our *de novo* review of the record, we agree with the ALJ's reliance on Dr. Lipman's complete, historically accurate and well-reasoned opinion, *Somers v. SAIF*, 77 Or App 259 (1986); *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), and write only to address the employer's legal argument on review.

The employer asserts that claimant cannot carry his burden to prove his hearing loss is compensable "merely by disproving other possible explanations of how the * * * disease occurred." ORS 656.266. Specifically, the employer argues that Dr. Lipman merely disproved the other six of the seven potential causes as the major contributing cause of claimant's hearing loss and, by deduction, concluded that claimant's work exposure to noise was the major contributing cause. We do not agree.

Here, Dr. Lipman properly evaluated the relative contribution of all possible causes of claimant's hearing loss. Moreover, his assessment of claimant's work exposure took into account the length of claimant's overall employment exposure (27 1/2 years of exposure to noisy machinery at a wood products mill); claimant's use of hearing protection (60 percent of the time he worked for the first 12 to 15 years; 99 percent of the second 12 to 15 years, although warn incorrectly); and audiogram evidence of claimant's increasing high-frequency hearing loss during his employment, which he considered to be causative factors in the work environment. This specific evidence goes beyond the a mere chronological connection and is legally sufficient under ORS 656.266. *Bronco Cleaners v. Velasquez*, 141 Or App 295, 298-99 (1996).

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 February 17, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500.

In the Matter of the Compensation of
ELEANOR B. YORK, Claimant
WCB Case No. 98-01628
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the insurer's denial of her current low back condition; and (2) upheld the insurer's denial of her left scapular condition. In its respondent's brief, the insurer challenges that portion of the ALJ's order that set aside its current condition denial as to claimant's trochanteric bursitis condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 71 at the time of hearing, had L4-sacrum fusion surgery in 1967 and 1969. She was compensably injured on June 22, 1995, when she slipped and fell on a wet floor. She landed on her tailbone and also bumped her head.

Claimant first sought medical treatment on July 5, 1995, complaining of pain primarily in the left buttock area. X-rays showed no acute injury. On July 14, 1995, claimant was referred to Dr. Stewart, who diagnosed the following: contusion, buttock; lumbar gluteal strain; trochanteric bursitis; preexisting degenerative disc disease of the lumbar spine; and preexisting fusion at L4 to sacrum.

The insurer accepted claimant's claim for lumbar strain and trochanteric bursitis. Claimant continued to treat with Dr. Bohme and Dr. Stewart for symptoms of back and hip pain through November 1995. She returned for treatment for back and hip pain in September 1996. Claimant was then released for regular work as of October 10, 1996.

Claimant's claim was closed by a January 28, 1997 Notice of Closure that awarded temporary disability only, based on Dr. Bohme's report that claimant was medically stationary without permanent impairment in October 1996. Claimant did not request reconsideration.

Meanwhile, at some point between October 1996 and January 21, 1997, claimant developed symptoms in the area of her left shoulder/scapula and thoracic spine. She reported the pain in her left scapula area to Dr. Bohme. Between February 1997 and April 1998, claimant treated with several physicians, including Drs. Bohme, Gallegos, Baum and Stiltson, for her left scapular area symptoms. Claimant also reported some low back pain radiating into her left leg.

In January 1998, the insurer issued a denial of claimant's current condition of back pain, asserting that her condition was related to preexisting conditions. The denial acknowledged that the insurer had accepted a lumbar strain and trochanteric bursitis in connection with the June 22, 1995 injury, but denied that claimant's current condition (back pain) was related to this compensable injury. In May 1998, claimant requested that the insurer accept a left shoulder condition, including a thoracic strain and fibrosis. In an August 1998 denial, the insurer contended that claimant's shoulder condition, thoracic strain and fibrosis were not related to her compensable injury. Claimant requested a hearing on both denials.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's current low back condition and her left shoulder/left scapular symptoms were not compensably related to her June 1995 industrial injury. We adopt and affirm these

determinations. The ALJ also determined that claimant's compensable trochanteric bursitis was at issue, and that it remained a component of her current condition and current need for treatment.[1]

As set forth below, we conclude that claimant's trochanteric bursitis condition was not at issue at hearing, and therefore the ALJ erred in setting aside the insurer's current condition denial in this regard.

An ALJ's scope of review is limited to issues raised by the parties. *Michael R. Petkovich*, 34 Van Natta 98 (1982), *see also Terry Hickman*, 48 Van Natta 1073 (1996). Here, at the outset of hearing, the parties agreed that the compensability issue involved claimant's current left-sided symptoms, primarily in the left shoulder, mid-thoracic area and low back. (*See* Tr. 2-4). Claimant did not assert that her accepted trochanteric bursitis was playing a role in her condition in 1998, nor did the insurer indicate that its denials encompassed any symptoms of trochanteric bursitis. Therefore, the trochanteric bursitis issue should not have been addressed in the ALJ's order.

Even if, as the ALJ noted, the insurer specifically requested a compensability finding regarding all specific conditions of record during closing arguments, the trochanteric bursitis issue was not timely raised. It is well-settled that an issue raised for the first time in closing argument should not be considered. *See, e.g., Lawrence E. Millsap*, 46 Van Natta 2112 (1995).

Because we interpret the insurer's January 1998 and August 1998 denials as encompassing claimant's current low back and left shoulder/scapular symptoms only (and we agree with the ALJ that claimant has not established the compensability of these conditions by a preponderance of the evidence), we uphold the denials in their entirety. Although claimant's trochanteric bursitis condition remains compensable, the condition was not at issue in this proceeding. Therefore, we reverse those portions of the ALJ's order that set aside the employer's denials in part and awarded a reasonable attorney fee for prevailing as to the trochanteric bursitis issue.

ORDER

The ALJ's order dated February 18, 1999 is affirmed in part and reversed in part. Those parts of the order that partially set aside the insurer's denials and awarded an attorney fee for finally prevailing on the trochanteric bursitis condition are reversed. The insurer's denials are reinstated and upheld in their entirety. The remainder of the order is affirmed.

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[1] In her reply brief, claimant contends that the insurer cannot challenge the compensability of her trochanteric bursitis condition because it did not file a cross-request for review. But, contrary to claimant's contention, it is well-settled that we are authorized to address issues raised by a non-appealing party provided that the formal request for review has not been withdrawn. *See Eder v. Pilcher Construction*, 89 Or App 425 (1988); *Neely v. SAIF*, 43 Or App 319 (1979), *rev. den.* 288 Or 493 (1980). Because the request for review has not been withdrawn, we may consider the insurer's objection.

In the Matter of the Compensation of
RICHARD D. FRYE, Claimant
WCB Case No. 98-0118M
OWN MOTION ORDER
Kirkpatrick & Zeitz, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable right knee strain injury. Claimant's aggravation rights expired on December 5, 1990. SAIF conceded that claimant remains in the work force and that his current right knee condition requires surgery. Nonetheless, SAIF recommends against reopening on the grounds that: (1) claimant's current condition is not causally related to the accepted condition; (2) SAIF is not responsible for claimant's current condition; and (3) it is unknown whether surgery or hospitalization is reasonable and necessary for the compensable injury. In addition, on March 10, 1998, SAIF denied compensability of claimant's current right knee condition and need for total right knee replacement.

Claimant filed a request for hearing with the Hearings Division regarding that denial. (WCB Case No. 98-02978). On May 12, 1998, the Board postponed action on the own motion matter pending resolution of the litigation regarding the compensability issue. On January 26, 1999, Administrative Law Judge (ALJ) Hazelett issued an order that upheld SAIF's March 10, 1998 denial. Claimant requested review of ALJ Hazelett's order and, by an order issued on today's date, the Board adopted and affirmed ALJ Hazelett's order.

Under our own motion jurisdiction, we are authorized to award disability in those cases where there has been a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). Here, the current condition for which claimant requests own motion relief remains in denied status. Consequently, we are without authority to authorize the reopening of claimant's claim for the payment of temporary disability benefits.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
GAYLE A. BRIGGS, Claimant
WCB Case Nos. 98-03080, 97-05463 & 97-00644
ORDER ON RECONSIDERATION
Swanson, Thomas & Coon, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys
Randy Rice, Defense Attorney

Claimant requests reconsideration of that portion of our June 16, 1999 Order on Review that found that he did not prove the compensability of a right hernia condition. Claimant contends that, although he asserted that the claim was compensable as an occupational disease, we limited our analysis to whether he proved that the condition was compensable as an industrial injury.

In making this assertion, claimant relies on the opinion of Dr. Braun. According to claimant, because Dr. Braun indicated that the inguinal hernia was related to "his on-the-job activities [] chronically acquired over a period of time," he carried his burden of proving an occupational disease.

In our order, we explained why we found Dr. Braun's opinion unpersuasive. We continue to adhere to that reasoning. Thus, whether as an industrial injury or occupational disease, we continue to conclude that claimant did not prove the compensability of the right hernia condition.

Accordingly, we withdraw our June 16, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Phillips Polich dissenting.

For the reasons expressed in my prior dissenting opinion, I continue to believe that claimant has established the compensability of his claim. Consequently, I adhere to my previous conclusion that the ALJ's order should be affirmed.

In the Matter of the Compensation of
GILBERT A. APPLEBAUM, Claimant
WCB Case No. 98-07902
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's 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 deny SAIF's request for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the portion of the ALJ's order that found claimant's left wrist condition was compensable.

Attorney Fees

Claimant requested a hearing challenging SAIF's denial of his left wrist condition. The ALJ found that claimant's left wrist condition was compensable and directed SAIF to accept and process that condition. The ALJ also awarded an attorney fee of $3,000.

On review, SAIF argues that the ALJ erred by failing to make specific findings of fact regarding each factor of OAR 438-015-0010(4) in awarding the assessed attorney fee. 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). 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, although the ALJ cited OAR 438-015-0010(4), he did not identify the factors considered in awarding the attorney fee. Because the ALJ's order lacks an explanation of those factors in determining the attorney fee in this case, we find the ALJ's reasoning insufficient to determine how he arrived at $3,000 as a reasonable fee. *See Donna R. Grierson*, 51 Van Natta 679 (1999); *compare Leslie D. Custer*, 51 Van Natta 390 (1999) (in the absence of a specific request or objection, ALJ's particular consideration of certain enumerated factors satisfies the *Underwood* rationale).

Although we find the ALJ's attorney fee discussion lacking in this case, 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 supplementation of findings regarding the attorney fee award. Consequently, we deny SAIF's motion to remand.

Our review of the record provides the following information. The issue at hearing was compensability of claimant's left wrist condition with a focus on his credibility. The hearing lasted one and one-half hours. Claimant and three other witnesses testified on his behalf. One witness testified on behalf of SAIF. The record consists of 9 exhibits, one of which was generated by claimant's attorney. The compensability/credibility issue was of average complexity. Because claimant's left wrist 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 attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were presented at hearing. Furthermore, in light of the credibility issue, there was a risk that claimant's counsel might go uncompensated.

Consequently, after considering the factors set forth in OAR 438-015-0010(4), we agree with the ALJ that $3,000 is a reasonable fee for claimant's attorney's services at hearing regarding the compensability issue. We therefore affirm the ALJ's attorney fee award. 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 regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated March 29, 1999 is affirmed.

In the Matter of the Compensation of
JOANNE C. BROYLES, Claimant
WCB Case No. 98-06742
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of her cervical injury claim. On review, the issue is compensability.

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

The ALJ upheld SAIF's denial, finding that claimant had failed to sustain her burden of proving that she sustained an injury at work on June 9, 1998 that was the major contributing cause of her cervical condition requiring surgery. In making this finding, the ALJ determined that the medical opinion of Dr. Brett, who concluded that a lifting event on June 9, 1998 was the major contributing cause of her cervical condition and need for treatment, was not persuasive.

On review, claimant contends that the ALJ improperly found that the case presented a complex medical issue, asserting that the parties had agreed that the sole issue was whether claimant proved that an injurious mechanism of injury had occurred on June 9, 1998. Claimant argues that she proved that such a mechanism did occur and, therefore, that her cervical claim is compensable. For the following reasons, we agree with the ALJ's decision to require expert medical evidence and his finding that claimant failed to sustain her burden of proof.

SAIF's counsel agreed with claimant's counsel's description of the issue as "the sole question in this case, and it is going to boil down to whether the injury occurred as [claimant] states that it did on June 9, 1998." (Tr. 6). While there is no question that claimant and a coworker engaged in lifting the lid of a dumpster on that date, there was a very real issue as to whether the lifting event was injurious to claimant's cervical spine. Claimant had experienced prior cervical symptoms, for which she had received chiropractic treatment. Claimant, herself, conceded that she did not immediately experience cervical symptoms after the lifting event and that it was at least an hour before they appeared. (Trs. 24, 33). Under these circumstances, we agree with the ALJ that expert medical evidence was required to prove that the lifting incident was "injurious," *i.e.*, the major contributing cause of claimant's need for treatment for her cervical spine. *See Barnett v. SAIF*, 122 Or App 279, 283 (1993).

With respect to that issue, we agree with the ALJ's reasons for finding Dr. Brett's opinion unpersuasive. Moreover, we do not agree with claimant's assertion that the opinion of an examining physician, Dr. Rosenbaum, supports compensability.

Dr. Rosenbaum opined that, if claimant was found to have had an injurious event which precipitated her radiculopathy on June 9, 1998, then the condition combined with preexisting cervical spondylosis, but that the major cause of the combined condition was the "injurious event." Dr.

Rosenbaum's response begs the question presented by this case, *i.e.*, whether the lifting event was injurious. More importantly, to the extent that it relies on a precipitating cause analysis, Dr. Rosenbaum's opinion is unpersuasive. *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); *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). Finally, the contemporaneous medical records of treatment on June 9, 1998 do not establish that claimant experienced radiculopathy on that date. (Ex. (9, 24). In sum, we do not find Dr. Rosenbaum's opinion persuasive to the extent that it supports the compensability of claimant's cervical condition.

In conclusion, claimant failed to sustain her burden of proving a compensable cervical injury claim. Therefore, we affirm.

ORDER

The ALJ's order dated February 26, 1999 is affirmed.

July 14, 1999 Cite as 51 Van Natta 1251 (1999)

In the Matter of the Compensation of
LEODEGARIO M. GOMEZ-MARTINEZ, Claimant
WCB Case No. 98-08959
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that increased claimant's award of scheduled permanent disability for loss of use or function of the left forearm from 8 percent (12 degrees), as granted by an Order on Reconsideration, to 14 percent (21 degrees). On review, the issue is scheduled permanent disability. We reverse and reinstate the award of scheduled permanent disability in the Order on Reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable left forearm injury on November 20, 1996, accepted as a nondisabling foreign body/laceration left forearm. The acceptance was later expanded to include left carpal tunnel syndrome.

On April 2, 1998, a Determination Order closed the claim with an award of 7 percent scheduled permanent disability for claimant's left forearm (wrist). Claimant requested reconsideration, which resulted in Dr. Filarski performing a medical arbiter's examination.

Based on the arbiter's report, an Order on Reconsideration increased claimant's scheduled award by 1 percent to a total of 8 percent for the left forearm (wrist/hand). Specifically, the Department determined that claimant was entitled to 6 percent hand impairment for loss of strength and 2 percent hand impairment for sensory loss in the middle phalanx of the ring finger and on the volar surface of the distal phalanx of the small finger. In making the award for the lost sensation in the middle phalanx of the ring finger, the Department determined that the "standards" did not address this disability and, therefore, promulgated a temporary rule to address the loss of sensation. (Ex. 26-3). Claimant requested a hearing from the reconsideration order.

The matter was submitted to the ALJ based on the documentary record. The parties, however, submitted written argument. In doing so, claimant only expressly contested the Department's calculation of impairment due to strength loss, arguing that he was entitled to 10 percent impairment for this disability, rather than the 6 percent awarded by the reconsideration order. Combining this 10 percent impairment with the 2 percent impairment the Department calculated for loss of sensation, claimant argued that his total scheduled permanent disability should be 12 percent.

The ALJ found that the Department's calculation of 6 percent impairment for loss of strength was correct. The ALJ then determined (in the absence of an express request by claimant) that the temporary rule addressing loss of sensation in the middle phalanx of the ring finger should have treated the sensory loss in that finger differently from the "standard" addressing loss of sensation in the distal phalanx of the little finger. The ALJ then awarded 20 percent impairment for sensory loss in the middle phalanx of the ring finger (2 percent of the hand), rather than the 13 percent impairment (1 percent of the hand) awarded by the temporary rule. The ALJ then determined that claimant was entitled to a 5 percent scheduled "chronic condition" award for the left wrist/hand, based on claimant's assertion that he could not hold employment due to wrist pain, coupled with Dr. Filarski's statement that claimant had residual discomfort during "function." Combining impairment values for strength loss (6), little finger sensory loss (1), ring finger sensory loss (2) and "chronic condition" (5), the ALJ awarded a total of 14 percent scheduled permanent disability, or 2 percent more than claimant requested.

On review, citing *Shubert v. Blue Chips*, 151 Or App 710 (1997), and noting that claimant had not questioned the reconsideration order's disability award for sensory loss, the insurer contends that the ALJ lacked authority to modify the temporary rule the Department promulgated. Moreover, the insurer notes that claimant did not assert entitlement to a "chronic condition" award. It contends that the ALJ incorrectly made such an award in the absence of supporting medical evidence. For the following reasons, we find the insurer's argument's persuasive.

At the outset, we note that an ALJ's review at hearing is limited to issues that the parties raised. *See Nikki Burbach*, 46 Van Natta 265, 268 (1994). Because claimant did not challenge the Department's award of permanent disability for loss of sensation in the middle phalanx of the ring finger, the ALJ should not have addressed the sensory-loss issue. Moreover, even if the issue was properly before the ALJ, he could not substitute his judgment for that of the Director regarding temporary rules promulgated under the disability standards. *See Shubert v. Blue Chips*, 151 Or App at 715.[1] Accordingly, we do not alter the reconsideration order's award of scheduled permanent disability for loss of sensation.

We now turn to the ALJ's "chronic condition" award. As previously noted, claimant expressly confined his argument to a request for an increased loss of strength award. Despite claimant's express request, the ALJ awarded 5 percent impairment for an alleged "chronic condition." Under such circumstances, we disagree with the ALJ's consideration of a "chronic condition" award. *Nikki Burbach*, 46 Van Natta at 268. Therefore, we reverse the ALJ's calculation of a 5 percent scheduled "chronic condition" award.

ORDER

The ALJ's order dated March 30, 1999 is reversed. The award of scheduled permanent disability in the Order on Reconsideration is reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee is also reversed.

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[1] Claimant contends that the ALJ's review of the Department's temporary review was proper because that review was based on a "finding of fact." No such finding of fact, however, appears among the ALJ's "findings of fact." Irrespective of this, claimant never contested the correctness of the temporary rule and, more importantly, the ALJ had no authority to substitute his judgment regarding the propriety of the temporary rule for that of the Department. *Id.*

In the Matter of the Compensation of
LINDA M. HANSEN, Claimant
WCB Case Nos. 97-00247 & 96-09661
ORDER ON REVIEW
Kryger, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) sets aside its partial denial of claimant's occupational disease claim for bilateral brachial plexus compression and thoracic outlet syndrome; (2) set aside its denial of claimant's current need for treatment and/or disability; (3) set aside its denials of claimant's aggravation claim of the accepted cervical strain and bilateral carpal tunnel syndrome conditions; and (4) awarded an assessed attorney fee of $4,600. On review, the issues are compensability, aggravation and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change.[1] In the last paragraph on page 2, we change the last sentence to read: "By August 24, 1994, Dr. Bufton reported that claimant's carpal tunnel syndrome had largely resolved and that her cervical pain was intermittent. (Ex. 20-1)."

CONCLUSIONS OF LAW AND OPINION

Compensability

In March 1994, claimant filed a claim for neck and upper extremity complaints. (Ex. 1). SAIF accepted a nondisabling cervical strain and bilateral carpal tunnel syndrome (CTS). (Ex. 14). By August 24, 1994, Dr. Bufton reported that claimant's carpal tunnel syndrome had largely resolved and that her cervical pain was intermittent. (Ex. 20-1).

On July 1, 1996, Dr. Adams signed a Notice of Claim for Aggravation of Occupational Injury or Disease. (Ex. 28). Dr. Adams reported that claimant had chronic neck pain that had been exacerbated lately by extreme stress on her job. (Ex. 27). She authorized time loss. (Exs. 27, 28).

On September 25, 1996, SAIF denied claimant's request to reopen the claim on the basis that the March 1994 injury was not the major contributing cause of her present need for treatment and/or disability. (Ex. 35). SAIF also stated that claimant's present need for treatment and/or disability was unrelated to the accepted conditions. (*Id.*)

On October 7, 1996, claimant signed an "801" form referring to a chronic strain going into the base of her neck, shoulders and causing cervical migraines. (Ex. 36a). SAIF denied claimant's occupational disease claim to her neck on January 6, 1997. (Ex. 38). SAIF amended the denial on January 15, 1997 to deny claimant's request to reopen the claim. (Ex. 39). SAIF asserted that the compensable cervical strain and bilateral CTS had not worsened and it also stated that the March 11, 1994 injury was not the major contributing cause of her present need for treatment and/or disability. (*Id.*)

On April 16, 1998, claimant's attorney requested that SAIF accept claimant's bilateral brachial plexus compression and thoracic outlet syndrome "[i]n accordance with ORS 656.262(6)(d) and ORS 656.262(7)(a)." (Ex. 40A).

On July 24, 1998, SAIF issued a partial denial of claimant's bilateral brachial plexus compression and thoracic outlet syndrome on the basis that the condition was not compensably related to the accepted claim for cervical strain or bilateral CTS. (Ex. 42).

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[1] We modify the ALJ's order to indicate that Exhibit 40A was also admitted in evidence. (Tr. 4).

The ALJ found that claimant had to establish a major contributing cause relationship whether she had a consequential condition or a new occupational disease. The ALJ relied on Dr. Konowalchuk's opinion and concluded that claimant's brachial plexus/thoracic outlet syndrome was compensable. The ALJ set aside three of SAIF's denials of claimant's "current condition as relating to the original claim."

On review, SAIF argues that the ALJ erred by setting aside its denials of claimant's aggravation claim, the current condition claim[2] and the claim for brachial plexus compression/thoracic outlet syndrome. SAIF contends, among other things, that the persuasive medical evidence establishes that claimant does not have brachial plexus compression/thoracic outlet syndrome.

Claimant relies on several theories to establish compensability. She contends that her current condition and need for treatment is the result of her work activities that were the basis of the original accepted claim in 1994, or in the alternative, was a consequence of that claim or a separate occupational disease. In either event, claimant argues that her current condition, including the currently diagnosed brachial plexus/thoracic outlet syndrome, is compensable under any of these theories.

The ALJ upheld SAIF's January 6, 1997 denial as it related to a new date of injury in June 1996. (Ex. 38). Because neither party raises this issue on review, we affirm the ALJ's decision upholding SAIF's January 6, 1997 denial.

Regarding SAIF's argument that the persuasive medical evidence establishes that claimant does not have brachial plexus compression/thoracic outlet syndrome, we adopt and affirm that portion of the ALJ's order that found Dr. Konowalchuk's opinion more persuasive than that of Dr. Olson. For the reasons expressed by the ALJ, we agree that Dr. Konowalchuk's reports establish that claimant does have a brachial plexus compression/thoracic outlet syndrome.

Moreover, we do not agree with SAIF's argument that there are no objective findings to support the diagnosis of brachial plexus compression/ thoracic outlet syndrome. SAIF relies on Dr. Konowalchuk's statement that "all these positive findings on physical examination are subjective rather than objective signs." (Ex. 40-4).

In previous cases, we have held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19). *See, e.g., Brian J. Taschereau*, 49 Van Natta 1760, *on recon* 49 Van Natta 1846 (1997); *Catherine Gross*, 48 Van Natta 99 (1996). 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.

Here, Dr. Konowalchuk reported that claimant's lateral neck flexion tests, an outreach test and a 3-minute abducted arm test all produced positive symptomatology suggestive of nerve derangement at the level of the brachial plexus (or thoracic outlet). (Ex. 40-3). He explained that sensory testing of the medial arm skin revealed abnormalities consistent with a problem at the brachial plexus level. (*Id.*) Dr. Konowalchuk found that provocative testing by application of pressure over possible upper extremity nerve entrapment sites revealed a "host of abnormalities" consistent with a lesion at the level of the brachial plexus. (*Id.*) He also found several positive Tinel's signs throughout the upper extremity that were indicative of a nerve injury. (*Id.*) He felt that claimant's measurements of static two-point discrimination greater than 2 mm were suggestive of nerve injury. (*Id.*) In a later report, Dr. Konowalchuk explained that claimant had diminished sensation in the medial arm and the fifth finger, which is the most common presentation of thoracic outlet syndrome. (Ex. 46-3). Dr. Konowalchuk concluded that the diagnosis of bilateral brachial plexus compression and thoracic outlet syndrome was supported by claimant's pattern of headache, neck, upper extremity, and parascapular pain, as well as positive provocative testing. (Ex. 40-4).

Although Dr. Konowalchuk commented that claimant's findings were "subjective" rather than objective (Ex. 40-4), we are not bound by his conclusion if the examination findings otherwise satisfy ORS 656.005(19). Based on the aforementioned findings from Dr. Konowalchuk, we find that claimant had objective findings of bilateral brachial plexus compression/thoracic outlet syndrome, which included diminished sensation and positive Tinel's signs. Those findings satisfy the definition of "objective findings" under ORS 656.005(19). *See, e.g., Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997).

With regard to claimant's brachial plexus compression/thoracic outlet syndrome, 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 *Dibrito v. SAIF*, 319 Or 244, 248 (1994)). Because of the multiple possible causes of claimant's disability or need for treatment, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

Claimant contends, among other things, that the brachial plexus/thoracic outlet syndrome is compensable as a separate occupational disease. 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).

SAIF argues that ORS 656.802(2)(b) applies to this case. SAIF contends that claimant has a preexisting anatomic anomaly and, therefore, she has not established that the preexisting condition has pathologically worsened.

Dr. Konowalchuk diagnosed claimant with bilateral brachial plexus compression and thoracic outlet syndrome and he felt that claimant's work activity was the major contributing cause of her condition. (Ex. 40-4, -5). Dr. Konowalchuk was asked whether claimant had any preexisting conditions that combined with her work-related condition to cause symptoms and a need for treatment. He responded that claimant had preexisting mammary hypertrophy, which can predispose to thoracic outlet-like symptoms. (Ex. 40-6). He did not believe that was the major contributing cause, however, because claimant's symptoms persisted despite the reduction mammoplasty. (*Id.*) There is no evidence claimant had a worsening of that condition. Dr. Konowalchuk referred to another preexisting condition:

> "Thoracic outlet syndrome will frequently have an anatomic basis. A person is born with their particular anatomy, and anatomic relationships usually cease to change with the cessation of growth. Thus, if an anatomic factor were the major contributing cause of her thoracic outlet syndrome, one would have expected the symptoms to begin earlier in her life. That there may be some anatomic basis to her development of thoracic outlet syndrome cannot be denied; however, it appears unlikely that it is the only causative factor in her development of this condition." (Ex. 40-7).

He concluded that the combination of predisposing work-related activities, "anatomic predisposition," and "possible" motor vehicle accident predispositions contributed to her thoracic outlet condition. (*Id.*)

Dr. Konowalchuk's opinion indicates that claimant had an anatomic predisposition to thoracic outlet syndrome that was congenital in nature. (Ex. 40-7). 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[.]" (Emphasis supplied). Because Dr. Konowalchuk indicated claimant had a congenital abnormality that predisposed her to thoracic outlet syndrome, that abnormality necessarily preceded the onset of her employment. Based on Dr. Konowalchuk's opinion, we find that the claim for brachial plexus/thoracic outlet syndrome is based on the worsening of a preexisting disease or condition and, therefore, ORS 656.802(2)(b) applies. Claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

Dr. Konowalchuk did not believe claimant's congenital anatomic predisposition was the major contributing cause of her thoracic outlet syndrome. (Ex. 40-7). He explained that if the anatomic factor was the major contributing cause of the thoracic outlet syndrome, her symptoms would have begun earlier in her life. (*Id.*)

Instead, Dr. Konowalchuk believed that claimant's work activity was the major contributing cause of her bilateral brachial plexus compression and thoracic outlet syndrome. (Ex. 40-5). He concluded that claimant's symptoms were related in major part to her work activities. (Exs. 40-1, -5, -7). He explained that, despite claimant's anatomic predisposition, her symptoms did not begin until she

had been working two years for the employer in Lincoln City. (Ex. 40-1, -7). He reported that claimant had "progressive neck and upper extremity dysfunction" related to her work activities. (Ex. 40-5). Dr. Konowalchuk concluded that claimant's work-related activities were the major contributing cause of her condition "because of the previously documented temporal relationship between these activities and the exacerbation of her problem." (Ex. 40-7). Although Dr. Konowalchuk did not expressly state that claimant's work activities were the major contributing cause of the pathological worsening of a preexisting condition, it is well settled that "magic words" are not necessary to establish medical causation. *See Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). We find that Dr. Konowalchuk's references to "progressive neck and upper extremity dysfunction" and the "exacerbation" of her condition establish that she had a pathological worsening of her preexisting anatomic condition. Furthermore, Dr. Konowalchuk's opinion establishes that claimant's work activities were the major contributing cause of the combined condition and pathological worsening of a preexisting condition. We conclude that claimant's bilateral brachial plexus compression/thoracic outlet syndrome is compensable as a separate occupational disease.[2]

Claimant also filed an aggravation claim. Although the ALJ set aside SAIF's September 25, 1996 and January 15, 1997 denials of claimant's aggravation claim, we are not persuaded that claimant has established an actual worsening of a compensable condition under ORS 656.273(1).

Claimant's compensable conditions are a cervical strain and bilateral CTS. (Ex. 14). Dr. Adams signed a Notice of Claim for Aggravation of Occupational Injury or Disease on July 1, 1996. (Ex. 28). Dr. Adams reported that claimant had chronic neck pain that had been "exacerbated" lately by extreme stress on her job. (Exs. 25-3, 27). She explained that "stress apparently exacerbates the pain." (Ex. 25-3). On June 27, 1996, Mr. Karnes, claimant's counselor, reported that claimant displayed symptoms of major depression and anxiety related to job stress and he felt she would benefit from a few weeks off work. (Ex. 26). Dr. Adams authorized time off work. (Exs. 27, 28). On July 11, 1996, Dr. Adams reported that claimant was being treated for headache, cervical strain and stress-related conditions. (Ex. 29a).

We are not persuaded claimant has sustained an "actual worsening" of either the cervical strain or the CTS. Claimant testified that no specific incident occurred in June 1996 to cause her symptoms to worsen. (Tr. 28). She testified that "[i]t was the same thing. It just was -- flared up worse than it had ever been." (*Id.*) On November 12, 1996, Dr. Tsai examined claimant on behalf of SAIF. (Ex. 37). He concluded that claimant's cervical strain had resolved by May 1994 and was no longer a material contributing cause of her need for treatment and/or disability. (Ex. 37-16). He did not diagnose any conditions related to claimant's CTS. Likewise, Dr. Adams made no reference to claimant's CTS condition or any worsening thereof. Although Dr. Adams said that claimant's neck pain had been exacerbated, we find that her reports suggest a waxing and waning of claimant's neck symptoms. The medical reports from Dr. Adams and Mr. Karnes indicate that claimant's treatment was in part for psychological conditions resulting from job stress, which were not previously compensable. We are not persuaded that claimant had an "actual" or pathological worsening of her cervical strain or CTS. We therefore reverse that portion of the ALJ's order that set aside SAIF's September 25, 1996 and January 15, 1997 denials of claimant's aggravation claim.

Attorney Fees

SAIF argues that the ALJ's attorney fee award of $4,600 is excessive. SAIF asserts that a more reasonable fee would be $3,300.

Claimant contends the ALJ's attorney fee award is reasonable, particularly because this is a contingency fee case. At hearing, claimant's attorney submitted a statement of services requesting a fee of $4,950. Claimant's attorneys indicated spent 22 hours on this case. The ALJ set aside three of four denials from SAIF and, after carefully considering the factors in OAR 438-015-0010(4), the ALJ awarded an attorney fee of $4,600.

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[2] In light of our conclusion that the brachial plexus compression/thoracic outlet syndrome is compensable as an occupational disease, we need not address whether it is compensable as a consequential condition.

On review, we affirm the ALJ's decision to uphold SAIF's January 6, 1997 denial. We also affirm the ALJ's decision to set aside SAIF's July 24, 1998 partial denial of claimant's bilateral brachial plexus compression/thoracic outlet syndrome. (Ex. 42). We uphold SAIF's September 25, 1996 and January 15, 1997 denials to the extent that they denied claimant's aggravation claim. (Exs. 35, 39). On the other hand, we set aside SAIF's September 25, 1996 and January 15, 1997 denials to the extent they denied compensability of claimant's current condition.

We agree with SAIF that, because we have upheld its denials of claimant's aggravation claim, the attorney fee award at hearing should be reduced. We determine the amount of claimant's counsel's attorney fee for services at hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in this case included compensability of claimant's current condition and bilateral brachial plexus compression/thoracic outlet syndrome. Claimant's attorneys indicated that they devoted 22 hours to the case at hearing. We agree with the ALJ that the issues in this case were of above-average complexity. Fifty-two exhibits were received into evidence, five of which were submitted by claimant's counsel. There was one deposition, which had a 23-page transcript. The hearing lasted three hours. Claimant testified on her own behalf. Because claimant's brachial plexus compression/thoracic outlet syndrome has been found compensable, she is entitled to workers' compensation benefits, and the value of the interest involved and the benefit secured for claimant are significant. The value of the claim may potentially include surgery and permanent disability benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might go uncompensated. After considering these factors, we conclude that $3,900 is a reasonable assessed attorney fee for claimant's counsel's services at hearing.

Claimant's attorney is entitled to an assessed fee for services on review related to the compensability of the current condition and brachial plexus compression/thoracic outlet syndrome. 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 $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 February 3, 1999 is affirmed in part, modified in part and reversed in part. That portion of the ALJ's order that set aside SAIF's September 25, 1996 and January 15, 1997 denials of claimant's aggravation claim is reversed. Those denials are reinstated and upheld. The ALJ's attorney fee award for services at hearing is reduced to $3,900. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
SUSAN M. HUGGINS, Claimant
WCB Case No. 98-02106
ORDER ON REVIEW
Adams, Day, Kangas & Vaneaton, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) admitted Exhibit 41; and (2) set aside its *de facto* denials of claimant's injury claims for lumbosacral strain, thoracic strain, cervical strain, right rib fracture at mid-axillary line and right hip trochanteric bursitis. On review, the issues are evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant was compensably injured in a motor vehicle accident on January 20, 1997. (Ex. 1). She was sitting in the right passenger side and the other car broadsided their car on the right side. (Ex. 2). She sought treatment in the emergency room, complaining of right hip pain, upper right leg pain and discomfort to the mid chest area. (*Id.*) Dr. Saavedra diagnosed a right hip contusion. (*Id.*)

The following day, claimant again sought emergency room treatment for neck, chest, right hip and thigh pain. (Tr. 19, Exs. 3a, 5). The diagnosis was multiple contusions and muscular ligamentous straining and the differential diagnosis was [m]ultiple contusions with muscular ligamentous strain, consider fracture." (Exs. 3a, 5). X-rays of claimant's chest on January 21, 1997 showed no post-traumatic change, but the radiologist noted "this is not a rib technique study and, therefore, subtle rib fractures could be missed." (Ex. 3). The radiologist concluded that "[w]ithin the limitation of the study there is no sign of rib fracture or other acute osseous change." (*Id.*)

Claimant was examined by Dr. Hall on January 24, 1997. (Ex. 6). He explained that claimant's thoracic and lumbar spine had decreased lateral and rotatory motion. (Ex. 6-2). She had tenderness at the costochondral junction of 4, 5 and 6 on the right and also the sternochondral junctions. (*Id.*) She also had pain with motion of the hip and with pressure on the sacrum. (*Id.*) He noted that claimant's x-rays were normal. (*Id.*) Dr. Hall diagnosed thoracic and lumbar strain, costochondritis, pelvic pain and right hip pain. (Ex. 7). On January 30, 1997, claimant described coccygeal pain. (Ex. 8). In February 1997, Dr. Hall referred claimant to Dr. Moore. (Ex. 11).

Dr. Moore examined claimant on February 7, 1997. (Ex. 12). Dr. Moore diagnosed soft tissue contusion, noting that it was unclear whether claimant had a very low pain threshold or whether there were other factors involved to account for her symptoms. (Ex. 12-3). One week later, Dr. Moore reported that claimant's pain behavior was very high and it was impossible to really examine her in any detail. (Ex. 13).

SAIF accepted the claim as disabling for right hip contusion, right posterior upper leg contusion and right anterior chest wall contusion. (Ex. 15).

On February 21, 1997, Dr. Moore diagnosed soft tissue contusion with continued pain and evidence of possible somatization. (Ex. 16). In March 1997, Dr. Moore also diagnosed depression. (Exs. 17, 18). Dr. Moore recommended aggressive functional therapy and claimant made excellent progress. (Exs. 22, 24). On May 8, 1997, Dr. Moore reported that claimant was medically stationary. (Ex. 29).

A Notice of Closure issued on May 22, 1997 that did not award any permanent disability. (Ex. 32). Claimant requested reconsideration and Dr. Becker performed a medical arbiter examination. (Exs. 34, 36). A September 25, 1997 Order on Reconsideration affirmed the Notice of Closure. (Ex. 37).

On February 10, 1998, claimant's attorney wrote to SAIF, requesting that SAIF revise the acceptance to include lumbosacral strain, thoracic strain, cervical strain and right shoulder strain, pursuant to ORS 656.262(6)(d). (Ex. 38). Claimant's attorney also requested that SAIF accept right rib fracture(s) and right hip trochanteric bursitis, pursuant to ORS 656.262(7)(a). (*Id.*) SAIF did not respond and claimant filed a request for hearing, alleging a *de facto* denial of these conditions.

CONCLUSIONS OF LAW AND OPINION

Evidence

At the June 4, 1998 hearing, the ALJ kept the record open for Dr. Moore's deposition. After Dr. Moore's deposition, claimant submitted Exhibit 41, which was an August 5, 1998 report from Dr. Hall. SAIF objected to Exhibit 41, noting that the record was left open only for the deposition. The ALJ admitted Exhibit 41, reasoning that claimant was entitled to the last presentation of evidence.

On review, SAIF argues that the ALJ erred by admitting the August 5, 1998 report from Dr. Hall (Exhibit 41). We need not address SAIF's evidentiary argument regarding Exhibit 41 because, even if we disregard that report, it would not affect the outcome of this case. Therefore, we decline to consider whether the ALJ abused her discretion by admitting Exhibit 41. *See Mario F. Torres*, 49 Van Natta 2074 (1997); *Larry D. Poor*, 46 Van Natta 2451 (1994).

Compensability

The ALJ found that the medical arbiter's report was persuasive evidence that claimant had sustained right hip trochanteric bursitis and a rib fracture at the mid-axillary line to the seventh or eighth rib from the work injury. The ALJ found that SAIF's acceptance did not reasonably apprise medical providers of all the compensable conditions resulting from the accident. The ALJ concluded that claimant had a compensable lumbosacral strain, thoracic strain, cervical strain, right rib fracture at the mid-axillary line and right hip trochanteric bursitis. The ALJ found the evidence was insufficient to support a diagnosis of right shoulder strain.[1]

On review, SAIF relies on Dr. Moore's opinion to argue that the ALJ erred in finding that the additional conditions were compensable. 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, 282 (1993). In evaluating the medical evidence, 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 agree with SAIF that the medical evidence does not establish compensability of right rib fracture at the mid-axillary line. X-rays of claimant's chest on January 21, 1997 showed no post-traumatic change, but the radiologist noted "this is not a rib technique study and, therefore, subtle rib fractures could be missed." (Ex. 3). The radiologist concluded that "[w]ithin the limitation of the study there is no sign of rib fracture or other acute osseous change." (*Id.*)

On September 8, 1997, Dr. Becker, the medical arbiter, reported that claimant's x-rays were all negative for fracture or pathology. (Ex. 36-4). Nevertheless, he diagnosed "[c]ontusion, right rib cage, probable healing rib fracture at mid-axillary line, seventh or eighth ribs, or both, dating to and consistent with history of January 20, 1997." (*Id.*) Dr. Becker explained:

> "Hard objective findings of impairment in the right chest wall are not present. There is *suspected* to be a fracture rib, healing, although the initial x-ray was a chest x-ray, no fracture was appreciated. The technique was not specifically for ribs." (Ex. 36-5; emphasis supplied).

Dr. Moore felt it was uncertain whether claimant had a right rib fracture, although he noted in his deposition that it would have been possible to find out. (Exs. 39-2 ,40-33).

Claimant has the burden of proving compensability of a right rib fracture. Dr. Becker's comment that he "suspected" a rib fracture indicates a possibility that claimant sustained a rib fracture. *See Gormley v. SAIF*, 52 Or App 1055 (1981). Without any objective evidence of a rib fracture and in light of Dr. Moore's opinion, we are not persuaded by Dr. Becker's opinion. We conclude that claimant has failed to establish compensability of a right rib fracture.

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[1] Because claimant does not argue on review that the right shoulder strain is compensable, we do not address that issue.

Dr. Becker also diagnosed "healing trochanteric bursitis" resulting from claimant's January 20, 1997 injury. (Ex. 36-4). He noted that the right hip contusion and trochanteric bursitis were "consistent with mechanism of injury and history." (*Id.*)

Dr. Becker examined claimant on only one occasion. On the other hand, Dr. Moore treated claimant on several occasions and had an opportunity to observe her over an extended period of time. Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Dr. Moore agreed that claimant did not have trochanteric bursitis. (Ex. 39-2). At a deposition, he explained that claimant's tenderness in the trochanter region "doesn't necessarily mean she has bursitis." (Ex. 40-32). Dr. Moore only stated that it was possible that claimant had bursitis. (*Id.*) Based on Dr. Moore's opinion, we conclude that claimant has failed to establish that she developed trochanteric bursitis as a result of the accident.

Although claimant asserts that she sustained a cervical strain after the work injury, we find no persuasive medical evidence that establishes compensability. Dr. Moore agreed that claimant's accident did not result in a cervical strain. (Ex. 39-1). He explained that claimant's complaints were primarily in the pelvic sacral and upper thigh areas. (Ex. 40-23). Dr. Moore testified that he would not diagnose a cervical strain and he noted those were not prominent symptoms. (Ex. 40-43). Similarly, Dr. Hall did not diagnose a cervical strain. (Ex. 7).

Compensability of claimant's lumbosacral and thoracic strain is more problematic. Although Dr. Moore initially agreed with SAIF that claimant did not sustain a lumbosacral or thoracic strain as a result of the accident (Ex. 39-2), he later testified that "[w]here you cross that line and say that there was actual strain becomes a judgment call which probably should be made by the doctor who examines the patient at the time of the acute injury." (Ex. 40-25). He did not believe he should comment on what Dr. Hall "saw when he evaluated the patient, what symptom complaints she had, what physical findings." (*Id.*) Dr. Moore testified that he "would say go back to the physicians on these other issues if you want to get an accurate diagnosis." (Ex. 40-26). Dr. Moore explained earlier that after reviewing the medical reports shortly after claimant's accident, he would diagnose "something to the effect of multiple contusions and *musculoligamentous straining* over the right cervical chest, pelvic and proximal thigh regions[.]" (Exs. 40-13, -14; emphasis supplied). He testified that by the time he examined claimant, it was well established that she had a "contusion *strain* type of problem." (Exs. 40-17, 18; emphasis supplied). The exercises recommended by Dr. Moore were related to the thoracic lumbar spine and pelvis. (Ex. 40-20).

In the deposition, Dr. Moore testified that claimant's "symptoms that she had over a fairly wide area are consistent with strain." (Ex. 40-24). He later testified, however, that he felt uncomfortable using the term "strain." (Ex. 40-31, -44). Dr. Moore felt it was much more likely that claimant had a contusion rather than a strain, but he noted that he did not examine her immediately after the accident and did not make the initial judgment call. (Exs. 40-31, -34).

Although Dr. Moore felt it was more likely that claimant had sustained a contusion than a strain, he testified that claimant's symptoms were consistent with a strain and he felt she had a "contusion strain type of problem" and "musculoligamentous straining." (Exs. 40-14, -17, -18, -24). Dr. Moore explained that the diagnosis of a strain should be made by the doctor who initially examined the patient and he felt those physicians would have an accurate diagnosis. (Exs. 40-24, -25, -26). Dr. Moore made those comments despite his belief that claimant had demonstrated some functional behavior during her treatment. (Exs. 40-38, -39).

One day after the accident, claimant was diagnosed with multiple contusions with muscular ligamentous strain. (Exs. 3a, 5). Dr. Hall examined claimant four days after the accident and explained that claimant's thoracic and lumbar spine had decreased lateral and rotatory motion. (Ex. 6-2). Dr. Hall diagnosed thoracic and lumbar strain. (Ex. 7). In light of Dr. Moore's comments that claimant had sustained a "contusion strain type of problem," his deference to the initial treating physicians, and Dr. Hall's diagnosis, we are persuaded that claimant sustained a thoracic and lumbar strain as a result of the motor vehicle accident.

Attorney Fees

The ALJ awarded an attorney fee of $3,000 for establishing compensability of claimant's lumbosacral strain, thoracic strain, cervical strain, right rib fracture at the mid-axillary line and right hip trochanteric bursitis. On review, SAIF contends that the attorney fee should be reduced if some of the conditions are found not to be compensable.

We have concluded that claimant has established compensability of a thoracic and lumbar strain. 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.

After the hearing, claimant's attorney submitted an affidavit, indicating that he had devoted 23 hours at $150 per hour to this claim. SAIF objected to claimant's request, noting that claimant's attorney's fee request included time devoted to the temporary disability issue, which had been bifurcated. Claimant's attorney responded that the amount of time he devoted to the temporary disability issue was 2.3 hours.

Our review of the record reveals the following information. Fifty exhibits were admitted in evidence, at least ten of which were submitted or generated by claimant's counsel. There was one deposition with a transcript of 45 pages. The hearing lasted one hour and five minutes and the transcript consists of 32 pages. Claimant testified on her own behalf.

As compared to typical compensability cases, the issues of claimant's thoracic and lumbar strain were of average complexity. Because claimant's strain conditions have 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 attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were presented at hearing. Furthermore, given the contradictory medical opinions, there was a risk that claimant's counsel might go uncompensated.

After considering the factors set forth in OAR 438-015-0010(4), we find that $2,600 is a reasonable fee for claimant's attorney's services at hearing. We therefore reduce the ALJ's attorney fee award.[2]

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 is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 21, 1998, as reconsidered March 10, 1999, is affirmed in part and reversed in part. The portion of the ALJ's order that set aside SAIF's *de facto* denials of a cervical strain, right rib fracture at mid-axillary line and right hip trochanteric bursitis is reversed. SAIF's denial of those conditions is reinstated and upheld. The ALJ's attorney fee award for claimant's attorney's services at hearing is reduced to $2,600. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

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[2] Claimant is not entitled to an attorney fee for his counsel's services regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

In the Matter of the Compensation of
THOMAS K. OSBORNE, Claimant
WCB Case No. 98-03136
ORDER ON REVIEW
Scott M. McNutt, Jr., Claimant Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of his occupational disease claim for hearing loss in his right ear. In its respondent's brief, the employer contests the ALJ's determination that the claim was timely filed. On review, the issues are compensability and (potentially) the timeliness of the claim filing.

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

The ALJ upheld the employer's denial of claimant's occupational disease claim for hearing loss in his right ear.[2] The ALJ concluded that the medical opinion of Dr. Shimotakahara, who evaluated claimant's hearing loss on two occasions, was insufficient to satisfy claimant's burden of proof. In reaching this conclusion, the ALJ noted that an audiologist (Dr. Ediger) prepared a chart based on an analysis of audiograms performed between 1966, when claimant began his employment, and 1998, when claimant's employment ended. According to Dr. Ediger's analysis, claimant's preexisting hearing loss (122dB) was slightly less than the hearing loss incurred between 1966 and 1998 (123dB). The ALJ reasoned that, if claimant's hearing loss between 1966 and 1998 was entirely noise induced, then his hearing loss would be compensable.

The ALJ, however, noted Dr. Shimotakahara's acknowledgment that hereditary factors contributed to claimant's hearing loss. Because a loss of two dBs or more due to hereditary factors would mean that employment noise could not be the major (more than 50 percent) cause of claimant's hearing loss, and because Dr. Shimotakahara did not quantify the amount of hearing loss due to hereditary factors, the ALJ did not find persuasive Dr. Shimotakahara's opinion that employment noise was the major contributing cause of claimant's hearing loss.

In addition to this reasoning, the ALJ also discounted Dr. Shimotakahara's opinion because he failed to address points made by an examining physician, Dr. Hodgson. Dr. Hodgson concluded that employment conditions were not the major contributing cause of claimant's hearing loss in part because audiograms revealed significant low level hearing loss not generally associated with noise-induced hearing loss. Moreover, according to the ALJ, Dr. Shimotakahara did not address Dr. Hodgson's observation that claimant's hearing loss was the most significant in later years of employment, when claimant wore hearing protection, than in earlier years when claimant did not use hearing-protection devices.

On review, claimant contends that Dr. Shimotakahara's opinion is the most persuasive. Specifically, claimants asserts that Dr. Hodgson and Dr. Ediger were either unaware of, or insufficiently considered, a March 1995 audiogram which showed a well-defined trough configuration at 4000 hz normally associated with noise-induced hearing loss. (Ex. 1). Moreover, claimant argues that Dr. Hodgson incorrectly assumed that claimant had adequate hearing protection during the last years of his employment when his hearing loss accelerated.

Initially, we note that Dr. Hodgson did not possess the March 1995 audiogram when he concluded that claimant's audiograms did not show the trough configuration at 4000 hz often associated with noise-induced hearing loss. (Ex. 11-26). In addition, claimant testified that he rarely wore the kind of hearing protection Dr. Hodgson believed he did. (Tr. 11). Despite these deficiencies in the medical evidence that is not supportive of claimant's claim, we, nevertheless, agree with the ALJ's decision to uphold the employer's denial.

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[1] Given our disposition of the compensability issue, we do not address the timeliness issue.

[2] The employer denied binaural hearing loss. (Ex. 8). Claimant, however, does not contend that hearing loss in the left ear is compensable.

Claimant has the burden of proving a compensable occupational disease claim. ORS 656.266. In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, the putative attending physician, Dr. Shimotakahara, only evaluated claimant's hearing loss on two occasions. (Exs. 1, 2). Therefore, Dr. Shimotakahara does not have a significant advantage over Drs. Hodgson and Ediger with respect to observation of claimant's hearing condition. More importantly, we find that the dispute (*i.e.*, whether claimant's hearing loss is work-related) involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979). Accordingly, we give the most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

Here, we agree with the ALJ that Dr. Shimotakahara's failure to clarify the amount of contribution to claimant's hearing loss from hereditary factors is significant given that claimant's preexisting hearing loss nearly equals the hearing loss incurred during claimant's employment. (Ex. 6-9). Further, Dr. Shimotakahara does not analyze the causation issue with Dr. Ediger's chart in mind. In addition, Dr. Shimotakahara does not rebut Dr. Hodgson's point regarding the presence of significant low level hearing loss which is not generally associated with noise-induced hearing loss. Because we do not find the sole opinion supporting compensability to be well-reasoned, we do not find that a preponderance of the evidence establishes noise-induced hearing loss at work was the major contributing cause of claimant's hearing loss in the right ear. Thus, we affirm.

ORDER

The ALJ's order dated February 1, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's decision to uphold the self-insured employer's denial of his occupational disease claim for hearing loss in the right ear. For the following reasons, I would find that claimant sustained his burden of proof.

First, presbycusis (or expected hearing loss due to aging) is a measure of "normal" hearing loss, as opposed to abnormal hearing loss. It does not, therefore, rise to the level of a "preexisting condition" under ORS 656.005(24). Accordingly, 100 percent of claimant's abnormal hearing loss is due to noisy employment conditions and is, thus, compensable.

Second, a precise percentage assessment of the contribution from various sources of hearing loss is not necessary for claimant to satisfy his burden of proof. In this case, both Dr. Hodgson and Dr. Ediger had flawed histories or inaccurate information. The majority appears to concede as much. Thus, there is no reason not to defer to the opinion of Dr. Shimotakahara, who had the most complete history and accurate information (including the critical March 1995 audiogram the majority concedes Dr. Hodgson did not possess). Dr. Shimotakahara concluded, based on a more than adequate fund of information, that work exposure to noise was the more than 50 percent cause of claimant's right-sided hearing loss. This conclusion seems quite reasonable given claimant's lengthy work history in a noisy environment that all doctors concede could have caused his hearing loss.

Because the majority refuses to find a meritorious hearing loss claim compensable, I dissent.

In the Matter of the Compensation of
CYNTHIA J. THIESFELD, Claimant
WCB Case Nos. 99-00054 & 98-07403
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Wallace, Klor & Mann, Defense Attorneys

Claimant requests reconsideration of that portion of our Order on Review that awarded a $1,000 attorney fee for services at hearing and on review for prevailing over the insurer's "de facto" and formal written denial of her claimed right shoulder conditions. Specifically, claimant asserts that the fee does not adequately compensate her counsel for services performed. For the reasons set forth below, we adhere to our decision.[1]

As set forth in our original order on review, claimant challenged three aspects of the Administrative Law Judge's (ALJ's) order: (1) the finding that the insurer's acceptance of claimant's right shoulder strain encompassed her subsequent diagnoses of rotator cuff tendinitis, subacromial tendinitis/bursitis, myofascial shoulder pain, parathesis in the right upper extremity and right shoulder impingement; (2) the absence of an attorney fee arising from the insurer's "de facto" and later formal written denial of the claimed shoulder conditions; and (3) the decision to uphold the insurer's denial of her consequential condition claim for a depression condition. Claimant also sought, for the first time on review, an assessed penalty for an allegedly unreasonable denial.

With regard to the claimed right shoulder conditions, claimant argued on review that the insurer's acceptance of a shoulder strain did not adequately apprise her and the medical providers of the nature of her compensable shoulder condition. Claimant also asserted that her claim for additional right shoulder conditions constituted "new medical condition" claims that existed independently of the initial claim and gave rise to separate processing obligations. We found to the contrary. After reviewing the medical record (particularly the opinion of claimant's attending physician, Dr. Walton), we agreed with the ALJ that the insurer's acceptance of a right shoulder strain encompassed the other right shoulder and right upper extremity diagnoses mentioned in the medical reports.

Even though we agreed that the insurer's acceptance of a right shoulder strain was sufficient to apprise claimant and the medical providers of the nature of her compensable shoulder condition, we found that, under the circumstances of the case, claimant's counsel was entitled to a reasonable attorney fee under ORS 656.386(1). Specifically, we determined that the case involved a "denied claim" under ORS 656.386(1)(b) because the insurer failed to respond to claimant's written communication under ORS 656.262(6)(d) within 30 days and later issued a formal denial of the claimed conditions.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to the case, we found that a reasonable fee for claimant's attorney's services at hearing and on review was $1,000. We stated that, in reaching this conclusion, we particularly considered the time devoted to the issue, the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Although claimant now contends that the $1,000 fee does not provide adequate compensation to her attorney, we note that claimant's counsel's statement of services at hearing did not specify the time spent on the claimed right shoulder conditions (as opposed to the claimed right hand/wrist and consequential depression conditions).[2] We also note that a significant portion of claimant's counsel's arguments at hearing and on review concerning the claimed right shoulder conditions were unsuccessful. Contrary to claimant's contention, we found that the claimed right shoulder conditions were subsumed by the insurer's acceptance and did not constitute distinct new medical conditions. Furthermore, despite the insurer's December 9, 1998 denial, the insurer took the position at hearing that the claimed right shoulder conditions were encompassed by its prior acceptance. Because the insurer essentially conceded at hearing that the claimed right shoulder conditions were compensable, the compensability issue was not particularly complex.

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[1] Although we acknowledge the insurer's July 9, 1999 letter, because we award no additional attorney fees, we find that the letter requires no further response.

[2] Furthermore, even assuming claimant's counsel indicated the time devoted to the claim for these particular conditions, the time devoted is only one of the eight factors to be considered in determining a reasonable fee.

Indeed, because the ALJ found that the claimed right shoulder conditions were compensable (although encompassed by the accepted strain) the only issues on which claimant truly prevailed on review were: (1) our clarification that the insurer's December 9, 1998 denial should be set aside as to the compensability of the claimed right shoulder and right upper extremity conditions;[3] and (2) claimant's counsel's entitlement to an attorney fee under ORS 656.386(1). In other words, all the Board did on review was correct an oversight and award an attorney fee. And it is well-settled that claimant is not entitled to an attorney fee for services related to the attorney fee issue. *See, e.g., 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).

Thus, after reconsidering the factors set forth in OAR 438-015-0010(4), particularly the complexity of the issue, the nature of the proceedings and the value of the interest involved, we adhere to our determination that $1,000 is a reasonable attorney fee for claimant's counsel's services with regard to the insurer's denial of the right shoulder and right upper extremity conditions.

Accordingly, we withdraw our June 17, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our June 17, 1999 order. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[3] As noted above, the ALJ found that claimant's claimed right shoulder and right upper extremity conditions were compensable, but his order erroneously upheld the insurer's December 9, 1998 denial of these conditions. On review, we reversed that portion of the ALJ's order that upheld the formal denial of these diagnosed conditions.

July 14, 1999 Cite as 51 Van Natta 1265 (1999)

In the Matter of the Compensation of
CHARLES A. WHITE, Claimant
WCB Case No. 98-05648
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that awarded a $4,500 assessed attorney fee. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings.

CONCLUSIONS OF LAW AND OPINION

On review, the insurer argues that the ALJ's assessed attorney fee award is excessive. The ALJ awarded claimant's counsel a $1,500 fee for his efforts in obtaining the insurer's pre-hearing rescission of its denial of claimant's left rotator cuff tendinitis and left lateral humeral epicondylitis. The ALJ awarded an additional $3,000 fee for claimant's counsel's services in prevailing over the insurer's denial of claimant's left acromioclavicular (AC) joint condition at hearing before the ALJ.

Claimant is entitled to a "reasonable" attorney fee for his counsel's efforts in prevailing over the insurer's denials. ORS 656.386(1). In determining a reasonable fee, we consider the following factors: the time devoted to the case; the complexity of the issues; the value of the interest involved; the skill of the attorneys; the nature of the proceedings; the benefit secured; the risk that an attorney's efforts may go uncompensated; and the assertion of frivolous issues or defenses. OAR 438-005-0010(4).

Here, the medical and legal issues are of average complexity, but the value of the interest involved and the benefit to claimant are substantial. The insurer initially accepted claimant's injury claim as a lumbar strain and left shoulder contusion. As a result of the efforts of claimant's counsel, the

insurer is now responsible for the additional conditions of left elbow epicondylitis, left rotator cuff tendinitis, and the combined condition of left acromioclavicular (AC) strain/arthritis. While the left elbow epicondylitis ultimately resolved after a year of treatment, claimant continues to suffer from the left shoulder tendinitis and combined AC joint conditions. Dr. Puziss has recommended a surgical resection and decompression for these left shoulder conditions, which would result in further temporary disability benefits. In addition, the left shoulder tendinitis and AC joint conditions may result in a permanent disability award.

Claimant's counsel has devoted a significant amount of time to this case. Counsel has represented claimant since March 30, 1998. Eight of the forty exhibits in the record were generated by claimant's counsel, including a written request for acceptance of claimant's left elbow condition, and a separate written request for acceptance of the left elbow epicondylitis, left rotator cuff tendinitis and left acromioclavicular (AC) strain. When the insurer did not issue a timely response to the latter request, claimant's counsel filed a request for hearing. Counsel also generated a written request for expedited approval of Dr. Puziss' proposed left shoulder surgery, and Dr. Puziss' October 9, 1998 response to Dr. Duff's September 15, 1998 opinion. The insurer did not accept claimant's left lateral epicondylitis and left rotator cuff tendinitis until the beginning of the hearing, and claimant's counsel litigated the compensability of the combined AC joint condition before the ALJ. The hearing lasted over two hours and included counsel's direct and redirect examination of claimant. Following the hearing, claimant's counsel expended further effort in obtaining the October 19, 1998 opinion from Dr. Puziss that established the compensability of the AC joint condition. Finally, claimant's counsel participated in post-hearing telephone closing argument.

Given the insurer's delay in responding to the request for acceptance of claimant's rotator cuff tendinitis and epicondylitis, there was some risk that these conditions would not be accepted. There was an even greater risk that the combined AC joint condition would not be found compensable in light of Dr. Duff's opinion that claimant's preexisting arthritis was the major contributing cause of the combined condition. Finally, claimant's counsel and the insurer's attorney are both experienced litigators, and no frivolous issues were asserted.

After considering these factors, we conclude that the ALJ's $4,500 attorney 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 February 18, 1999 order is affirmed.

In the Matter of the Compensation of
THOMAS C. ACHEN, Claimant
WCB Case No. C991566
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Scott M. McNutt, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

On June 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.

Here, the first page of the proposed agreement provides a total consideration of $14,000, with claimant receiving $10,725 and claimant's attorney receiving an attorney fee of $3,275 payable out of the CDA proceeds. However, the body of the CDA provides (on page 3) that, "[c]laimant and his attorney agree to a reduced attorney fee." The attorney fee has been reduced to $3,125 and the amount payable to claimant has been increased to $10,875.

In interpreting a 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. *See Carol J. Mullins*, 51 Van Natta 198 (1999). Accordingly, here, consistent with the specific provisions in the body of the agreement, we interpret the CDA as providing for a total consideration of $14,000, with an attorney fee of $3,125 payable to claimant's attorney and $10,875 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' CDA is approved. An attorney fee of $3,125, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LYNN M. BROWN, Claimant
WCB Case No. 96-05732
ORDER ON REMAND
Greg Noble, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Phillips Polich, and Bock.

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Brown*, 159 Or App 440 (1999). The court has reversed our prior order, *Lynn M. Brown*, 49 Van Natta 1136 (1997) (Board Member Haynes dissenting), that reversed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a mental disorder. Concluding that it was unable to determine whether we had considered or decided that claimant had satisfied her burden of proof by "clear and convincing" evidence regarding the causation of her mental disorder claim under ORS 656.802(3)(d), the court has remanded for reconsideration. In accordance with the court's mandate, we now proceed with that reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the procedural and factual background of the claim. On December 14, 1995, three men entered the convenience store in which claimant was employed as a cashier/clerk. When one of the men attempted to leave the store without paying for an item, claimant confronted the individual. One of the other men struck claimant in the face, breaking her glasses. Claimant also sustained a laceration under the left eye, which required emergency room treatment. SAIF accepted a nondisabling claim for a laceration and left cheek contusion.

In March 1996, claimant treated with her family physician, Dr. Schwerzler, for her facial injuries. Diagnosing "post traumatic stress syndrome," Dr. Schwerzler referred claimant to a psychologist, Dr. Malone, after claimant expressed anxiety, fear, and depression when she had to work alone. Dr. Malone diagnosed post traumatic stress disorder (PTSD).

SAIF denied the PTSD condition on May 23, 1996. Claimant appealed the denial.

The ALJ upheld SAIF's denial of claimant's mental disorder claim, reasoning that claimant failed to prove that she had a diagnosable mental disorder. *See* ORS 656.802(3)(c). In making this compensability determination, the ALJ relied on the medical opinion of examining psychiatrist Dr. Klecan, who opined that claimant did not meet the diagnostic criteria for PTSD, over the opinions of Dr. Schwerzler and Dr. Malone. Claimant requested Board review.

On review, we found Dr. Malone's opinion (as supported by Dr. Schwerzler) persuasive because it was thorough, well-reasoned, and based on extensive familiarity with claimant's psychological symptoms. Moreover, we found Dr. Malone's opinion considerably more persuasive than Dr. Klecan's opinion. Therefore, we concluded that claimant satisfied her burden of proving that she suffered a compensable mental disorder (PTSD) as a result of a work-related assault on December 14, 1995. Finding that there was no dispute that claimant's psychological claim satisfied the other statutory criteria in ORS 656.802(3), we reversed the ALJ's decision upholding SAIF's denial. SAIF then sought review before the Court of Appeals.

Before the court, SAIF argued that we had improperly refused to discount the treating physicians' opinions based on their alleged incomplete information regarding the presence of off-work stressors. SAIF contended that we rendered our own medical opinion when we concluded that the off-work stressors had resolved or improved before the assault occurred. SAIF also asserted that claimant did not prove by "clear and convincing" evidence that the mental disorder arose out of and in the course of employment.

Noting that SAIF had contended on Board review that the medical opinions were insufficient to satisfy claimant's burden of proving the claim by "clear and convincing" evidence (because the treating physicians had failed to address claimant's off-work stressors), the court stated that it could not determine whether we had considered only the "diagnosis" issue to be in dispute and issued our order on that ground alone, or whether we also considered the issue of whether claimant satisfied her burden under ORS 656.802(3)(d). *SAIF v. Brown*, 159 Or App at 445-6. Concluding that the Board's order was inadequate for review, the court reversed and remanded for reconsideration. *Id.*

At the outset, we observe that, in order to prove a compensable claim for a mental disorder, claimant in part must provide "clear and convincing" evidence that the mental condition arose out of and in the course of employment. ORS 656.802(3)(d). In order to be clear and convincing, the truth of the facts asserted must be "highly probable." *E.g. Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

We acknowledge that our order did not directly address the issue of whether claimant had proved by "clear and convincing" evidence that her mental disorder arose out of and in the course of employment, even though SAIF had contended that she had failed to do so. Instead, we perceived the primary issue as whether claimant had developed a generally recognized mental or emotional disorder as a result of the work-related assault. *Lynn M. Brown*, 49 Van Natta at 1137. We concluded that she had developed such a disorder. However, because we did not directly address the issue of "clear and convincing" evidence, we must do so now.

On reconsideration, our analysis of the medical evidence remains the same. That is, we still find the opinion of Dr. Malone, as supported by Dr. Schwerzler, more persuasive that of Dr. Klecan.[1] As to the question of whether the medical evidence supporting compensability rises to the level of "clear and convincing," we are persuaded that it does.[2] In other words, we find it "highly probable" that the work-related assault is the major contributing cause of claimant's PTSD.[3]

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[1] In our original order, we declined to discount Dr. Malone's medical opinion on the ground that he did not consider the impact of potential off-work stressors such as claimant's gambling debts, bankruptcy and marital difficulties. We reasoned that, because the evidence indicated that claimant's marital problems had improved, as had her financial difficulties, this did not fatally undermine Dr. Malone's opinion. *Id.* at 1138 n. 3. Before the court, SAIF argued that we had improperly rendered our own medical opinion when we concluded that off-work stressors had improved before the assault occurred. We disagree with SAIF's contention. We did not render a medical opinion. Rather, we drew legitimate inferences from the evidence in the record and concluded that Dr. Malone's opinion should not be discounted on the basis of insufficient consideration of off-the-job stressors. After further consideration of the matter, we continue to find Dr. Malone's opinion persuasive despite his alleged lack of information regarding off-work stressors.

[2] The medical evidence need not be unanimous in order for it to be "clear and convincing." Because the evidence supporting the claim is clear and well-reasoned (and in the absence of persuasive rebuttal from Dr. Klecan), we conclude that the claimant has established by "clear and convincing" evidence that her compensable injury caused her mental condition. *See Albert D. Avery*, 49 Van Natta 1771 (1997), *recon denied* 50 Van Natta 849 (1998) (finding mental disorder claim compensable by "clear and convincing" evidence even though the medical evidence was divided).

[3] For the reasons cited in her dissenting opinion in the original order, Board Member Haynes continues to believe that the mental disorder claim is not compensable.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 22, 1997 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAUL E. DAVIDSON, Claimant
Own Motion No. 99-0045M
OWN MOTION ORDER ON RECONSIDERATION
Cathcart & Borden, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

On May 4, 1999, we issued an Own Motion Order, which declined to reopen his 1993 industrial injury claim for the payment of temporary disability compensation. We took this action because claimant had withdrawn his request for hearing and thus concluded his current left shoulder condition remained in denied status. Contending that his request for hearing pertained solely to a claim for aggravation under ORS 656.273 and did not address his request for benefits under our own motion authority, claimant requests we reconsider our prior order.

On February 4, 1999, the self-insured employer submitted claimant's request for temporary disability compensation for his 1993 claim. The employer opposed reopening on the grounds that: (1) claimant's current condition did not require surgery or inpatient hospitalization; (2) the current left shoulder condition was not causally related to the accepted condition; (3) the employer was not responsible for claimant's current condition; and (4) surgery or hospitalization is not reasonable and necessary for the compensable injury.

On review of the employer's submission, we noted that claimant had requested a hearing regarding the compensability of his current left shoulder condition. Since there was litigation pending regarding claimant's 1993 claim, we postponed action until that litigation had been resolved. Claimant had actually filed a request for hearing appealing the employer's "defacto" denial of his claim for aggravation of his 1993 injury.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

Here, claimant's 1993 injury claim was accepted as disabling in April 1993. The claim was first closed on July 7, 1993. Thus, claimant's aggravation rights expired on July 7, 1998. Claimant's attending physician's Notice of Claim Aggravation was submitted to the employer on September 24, 1998, beyond the five year aggravation period. Therefore, at the time claimant's left shoulder condition worsened, claimant's 1993 claim was under our authority pursuant to ORS 656.278. *See Jody Crompton*, 48 Van Natta 1181 (1996).

When claimant discovered his claim was in "own motion" status, he withdrew his hearing request. An Order of Dismissal was issued on April 2, 1999. That order was not appealed. We concluded that the effect of the dismissal order was that claimant's current left shoulder condition remained in denied status. On May 4, 1999, we issued our Own Motion Order denying reopening of his 1993 claim because his current condition was not compensable.

As a result of claimant's initial confusion regarding the aggravation status of his 1993 claim and our interpretation of the effect of the dismissal order, there is some controversy regarding the compensability of claimant's current left shoulder condition. The employer indicated in its recommendation that it was disputing the compensability of and responsibility for claimant's current left shoulder condition as it related to his 1993 claim. However, the employer has not issued a formal denial. On reconsideration, claimant contends that since the employer has not issued a formal denial of his current condition, then the compensability issue is not "ripe" for litigation.

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.*

However, under our own motion jurisdiction, we do not have the authority to address compensability issues. Here, we need not address this issue because, even assuming that claimant's current condition is compensable, his 1993 claim does not qualify for reopening under ORS 656.278. We reach this conclusion based on the following reasoning.

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 Emergency Department Medical Record which demonstrates that claimant sought treatment for a left shoulder dislocation. He was given intravenous pain medication and his shoulder was reduced and splinted. Claimant was advised to see his orthopedic surgeon and discharged.

Because claimant had been admitted for emergency treatment and discharged that same day, that treatment does not constitute hospitalization. *See Melvin L. Wall*, 51 Van Natta 23 (1999); *Daniel P. Moore*, 46 Van Natta 2490 (1994). Furthermore, in a summary of a telephonic conversation between Dr. Harris, claimant's attending orthopedic physician, and the employer's attorney, Dr. Harris agreed that he had stated that claimant's current left shoulder condition required neither inpatient or outpatient surgery nor hospitalization.

Therefore, the record fails to demonstrate that claimant required *surgery* or *hospitalization* for treatment. As a result, we find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, no temporary disability compensation is due.

Accordingly, our May 4, 1999 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 4, 1999 order in its entirety. The parties rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES FRANZ, Claimant
Own Motion No. 99-0195M
INTERIM OWN MOTION ORDER CONSENTING TO DESIGNATION OF PAYING AGENT (ORS 656.307) AND AMENDED ORDER ABATING AND POSTPONING ACTION
Malagon, Moore, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On June 21, 1999, we issued an Own Motion Order of Abatement and Postponement of Action. We took this action because claimant requested reconsideration of our May 21, 1999 Own Motion Order and there was pending litigation before the Hearings Division regarding the compensability of claimant's current condition.[1] However, July 2, 1999, the Department notified us that it requests our approval for an order designating a paying agent contending that the only issue pending is the responsibility for claimant's current condition. Therefore, we withdraw of June 21, 1999 order and replaced by the following order.

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[1] The SAIF Corporation submitted a copy of its Disclaimer of Responsibility and Claim Denial with its recommendation to deny reopening of claimant's 1984 claim under ORS 656.278. SAIF contended that claimant's current condition was not causally related to the compensable injury and that it was not responsible for claimant's current condition.

Under OAR 438-012-0032, the Board shall notify 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 the payment of compensation. 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 1984 injury claim with SAIF expired on July 16, 1990. Thus, the claim is subject to ORS 656.278.

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). 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.*

With its request for reconsideration of our order, claimant submitted an April 23, 1999 chart note, in which Dr. Hacker, claimant's attending physician, recommended that claimant undergo an anterior cervical microdiscectomy with canal decompression and fusion at C6-7.

Here, the record establishes that there has been a worsening of claimant's compensable condition requiring surgery. Inasmuch as claimant would be entitled to Own Motion relief if the Own Motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1984 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. On June 21, 1999, we postponed action on claimant's request for reconsideration pending the outcome of litigation at the Hearings Division. (WCB Case No. 99-04212). As noted above, our prior order referred to the compensability of claimant's current condition. The record now demonstrates that compensability of claimant's current condition is not at issue. Thus, we are postponing action on the own motion matter based solely on the outcome of the responsibility dispute. We requested that, after the ALJ issues his order or if the matter is resolved by settlement agreement, the parties should advise the Board of their respective positions regarding Own Motion relief.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 21, 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.

July 15, 1999 Cite as 51 Van Natta 1271 (1999)

In the Matter of the Compensation of
ALFREDO G. GARCIA, Claimant
WCB Case No. 97-08876
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Reinisch, MacKenzie, 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 left knee injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the third paragraph on page 4, we delete the last sentence. In the sixth paragraph on page 4, we replace the second sentence with the following: "Because Dr. Read treated claimant on only one occasion, her opinion is not entitled to any particular deference as a treating physician." In the last paragraph on

page 4, we replace the fourth sentence with the following: "Dr. Read acknowledged that claimant's examination findings could be consistent with a diagnosis of a knee strain. (Ex. 16-10)." In the second full paragraph on page 5, we change the last sentence to read: "The record indicates that Dr. Ballard was provided copies of the reports from Drs. Schilperoort, Snider and French. (Ex. 17)."

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). Although claimant's attorney has requested an assessed fee of $2,000, he did not submit a statement of services showing the time devoted to the case on review. Claimant's respondent's brief is 6 pages in length. After considering the factors set forth 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 self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 19, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the self-insured employer.

In the Matter of the Compensation of
TERRANCE W. HEURUNG, Claimant
WCB Case No. 98-04914
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
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 self-insured employer's denial of his consequential condition claim for cold intolerance of the left knee; and (2) upheld the employer's denial of claimant's aggravation claim for a left thigh and left knee injury. On review, the issues are scope of acceptance, compensability and aggravation.

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

Claimant was compensably injured on January 4, 1995 when a heavy steel plate struck his left thigh. He sustained a severe contusion and deep laceration of the left thigh. The employer accepted these conditions on January 24, 1995.

Claimant continued to experience left knee symptoms. In February 1995, he began treating with Dr. Hermens, who diagnosed a lateral tibial plateau fracture and possible meniscus tears related to the compensable injury. Dr. Hermens performed arthroscopic surgery on claimant's left knee (including a partial medial menisectomy and extensive synovectomy) on April 17, 1997.

In July 1995, Dr. Hermens referred claimant to Dr. Busby, a plastic surgeon, to address a deformity of claimant's anterior left thigh resulting from the compensable injury. In March 1996, Dr. Busby performed a staged excision of the left anterior thigh scar tissue and advancement flap repair.

Meanwhile, claimant continued to treat with Dr. Hermens for follow-up of his left knee and tibial plateau injury. In August 1996, claimant reported that cold bothered his left thigh and knee. On September 17, 1996, Dr. Hermens performed a closing examination and declared claimant medically stationary with permanent impairment.

The claim was closed pursuant to a December 10, 1996 Notice of Closure that awarded 16 percent (24 degrees) scheduled permanent disability for the left leg. A May 9, 1997 Order on Reconsideration affirmed the Notice of Closure. In June 1997, the employer accepted claimant's left knee lateral tibial plateau fracture and post traumatic synovitis of the left knee.

During 1997, claimant experienced some sensitivity to cold in the area of his left thigh and knee. He used a heater in his work area that helped alleviate the problem. But in January 1998, claimant was advised that, for safety reasons, he could not continue using the heater in his work station. Once he stopped using the heater, the cold climate in the employer's shop began to bother his knee.

Claimant returned to Dr. Hermens on January 27, 1998 complaining of cold intolerance. Dr. Hermens reported that claimant's cold intolerance problem was based on subjective symptoms rather than verifiable objective findings. During the next several months, claimant's employer and Dr. Hermens were in contact regarding ways the employer could accommodate claimant's left thigh and knee cold intolerance, as the problem was affecting claimant's ability to work. Claimant tried a variety of modalities, including insulated clothing, without success. By June 1998, however, claimant was able to tolerate the shop's climate and he returned to work.

In July 1998, claimant was referred to Dr. Long, who diagnosed deep left thigh laceration, meniscal tear and cold intolerance. Dr. Long sent claimant for further testing to possibly document objective findings of cold intolerance.

On October 27, 1998, claimant was examined by Drs. Zivin and Duncan at the employer's request. Dr. Duncan reported that claimant had post traumatic left leg changes related to his injury and surgeries, but he found no objective neurological or vascular evidence of a cold intolerance condition. Dr. Zivin similarly found that claimant's cold intolerance was a subjective symptom of his compensable injury and not a separate condition.

Claimant filed an aggravation claim related to his compensable injury. In addition, claimant requested that the employer accept the cold intolerance of his left knee as a consequential condition. In a series of denials, the employer asserted that there was no objective evidence of a worsening of his compensable condition, that there was no objective evidence to support his cold intolerance as a consequential condition and that claimant did not have a new medical condition.

At hearing, claimant's counsel asserted that claimant's cold intolerance constituted a new medical condition, which had not been previously accepted by the employer. The employer, on the other hand, argued that claimant's cold intolerance was not a new medical condition, but rather a symptom of his accepted thigh and knee injury. The employer also contended that this subjective symptom was encompassed by its previous acceptances, and that claimant had not experienced any objective worsening of his condition since claim closure.

Noting that, under ORS 656.262(7)(a), 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, the ALJ found that the employer's acceptances encompassed claimant's left thigh and knee cold intolerance. Specifically, the ALJ concluded that claimant's cold intolerance was a residual symptom of his treatment for the compensable injury, but that this symptom did not constitute a distinct condition or diagnosis that must be formally accepted and separately processed. The ALJ also found no evidence of an actual worsening of claimant's condition since the last award or arrangement of compensation.

On review, claimant first asserts that because the employer's denial was based only on a lack of objective medical evidence, the "scope of acceptance" issue was not properly before the ALJ. We reject this contention.

Although the employer's June 17, 1998 denial denied the cold intolerance condition for lack of objective medical evidence, its December 9, 1998 denial asserted that claimant did not suffer from an additional condition. In this later denial, the employer contended that the diagnosis in issue "was descriptive only and did not contain any new conditions." (Ex. 62C). Further, in framing the issues at the outset of the hearing, the employer specifically argued that "the condition that was accepted as a laceration is the same condition for which the claimant now seeks additional benefits." (Tr. 6). Claimant did not object to the employer's characterization of the issue, and proceeded to litigate whether his cold intolerance constituted a separate new medical condition. By failing to assert that the employer's position at hearing went beyond the scope of its denials, claimant has waived any potential procedural challenge to the employer's denials and the scope of the ALJ's review. *See Christopher A. Callaway*, 50 Van Natta 2420 (1998) (*citing Thomas v. SAIF*, 64 Or App 193 (1983)).

Claimant also renews his assertion that his cold intolerance is a new medical condition and therefore the employer's acceptance (of a laceration) did not reasonably apprise him or his medical providers of the nature of his compensable condition. Like the ALJ, we find to the contrary.

Claimant's attending physician, Dr. Hermens, indicated on several occasions that claimant's cold intolerance is a subjective symptom of his compensable injury. (*See, e.g.*, Exs. 47, 54A, 55-2). Dr. Hermens also noted that claimant complained that the cold bothered him even before the claim was closed in late 1996, although it became more of a problem when he had to stop using the space heater in January 1998. (Ex. 49). Drs. Zivin and Duncan also opined that claimant's cold intolerance is a subjective, residual symptom of his laceration injury and subsequent surgical repair. (Exs. 61, 62, 62B). Indeed, Dr. Duncan explained that his diagnosis of post traumatic left leg changes related to a "reverse flap" was not a new condition, but rather a more descriptive term for claimant's symptoms. (Ex. 62B). Drs. Zivin and Duncan also reported that they found no vascular or neurological evidence of a distinct condition of "cold intolerance." (Ex. 61, 62).

Dr. Long, on the other hand, has opined that cold intolerance is different from the conditions accepted by the employer. (Ex. 65). But given the contrary opinions of Drs. Hermens, Zivin and Duncan (*i.e.*, that claimant's cold intolerance is a residual symptom associated with his surgery), Dr. Long's report does not persuade us that claimant's cold intolerance constitutes a new medical condition or distinct diagnosis that must be formally accepted in addition to the laceration injury.[1]

Consequently, on this record, we agree with the ALJ that the employer's acceptance of a thigh laceration injury reasonably apprises claimant and the medical providers of the nature of his compensable condition under ORS 656.262(7)(a). *See, e.g., Billy W. Wilson*, 50 Van Natta 1747 (1998) (the claimant's post-surgery complications--chronic pain in the left groin and along the surgical incision--did not constitute a new consequential condition under ORS 656.005(7)(a)(A); the carrier's acceptance of a left inguinal hernia injury reasonably apprised the claimant and medical providers of the nature of the compensable condition).

Finally, like the ALJ, we find no evidence of an actual worsening of claimant's compensable condition since the last award or arrangement of compensation.[2] Although Dr. Hermens noted that claimant's cold intolerance became "more of a problem" after the heater was removed from his work station in January 1998, he did not describe any actual worsening of claimant's physical condition. Similarly, Dr. Long did not opine that claimant's condition had pathologically changed or worsened since the claim was closed in December 1996. We therefore adopt and affirm the ALJ's decision to uphold the aggravation denial.

ORDER

The ALJ's order dated March 22, 1999 is affirmed.

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[1] Under ORS 656.262(7)(a), 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." *See Johansen v. SAIF*, 158 Or App 672, 679 (1999). Thus, a "new medical condition" is a distinct "condition" that is not encompassed by the carrier's acceptance of the initial claim.

[2] 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. *See SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997).

In the Matter of the Compensation of
VINCENT W. PROWELL, Claimant
WCB Case No. 98-07318
ORDER ON REVIEW
Ransom & Gilbertson, 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) Thye's order that awarded an assessed attorney fee of $3,500. 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.

Claimant requested a hearing challenging SAIF's denial of his current cervical condition. The ALJ found that claimant's current condition was compensable and directed SAIF to accept and process that condition. The ALJ also awarded an attorney fee of $3,500 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 erred by failing to make specific findings of fact regarding each factor of OAR 438-015-0010(4) in awarding the assessed attorney fee. 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999). 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 OAR 438-015-0010(4) and identified the factors considered in determining the fee. The ALJ said he considered the complexity of the issue, the value of the interest and benefit obtained for claimant and the risk that claimant's counsel might have gone 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); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).

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 regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated March 23, 1999 is affirmed.

In the Matter of the Compensation of
ROBERT S. RICHEY, Claimant
Own Motion No. 98-0521M
OWN MOTION ORDER
Richard F. McGinty, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

On February 11, 1999, we issued an Own Motion Order authorizing the payment of temporary disability compensation beginning December 28, 1998, the date claimant was hospitalized for surgery. In addition, the insurer was ordered to close the claim pursuant to OAR 438-010-0055, when claimant became medically stationary.

On April 26, 1999, a hearing was convened before Administrative Law Judge (ALJ) Johnson regarding the enforcement of our February 11, 1999 Own Motion Order. (WCB Case No. 99-02893). Following the hearing, and prior to the issuance of an order, ALJ Johnson discovered that the Hearings Division did not have jurisdiction over enforcement issues regarding claims under our authority pursuant to ORS 656.278. We have exclusive "own motion" jurisdiction to authorize the reopening of a claim under ORS 656.278 and OAR Chapter 438, Division 012 rules. *See Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Moreover, our jurisdiction includes the authority to enforce our own motion orders. *See Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Thomas L. Abel*, 45 Van Natta 1768 (1993); *Darlene M. Welfl*, 44 Van Natta 235 (1992). In light of these circumstances, ALJ Johnson deferred issuance of an order pending our decision regarding claimant's enforcement request of our February 11, 1999 Own Motion Order.

In a May 20, 1999 letter to us, claimant requested review of the insurer's May 19, 1999 Notice of Closure. However, claimant noted that an evidentiary hearing had taken place before ALJ Johnson which dealt with issues that were potentially raised by the issuance of the closure. He requested that we advise the parties "how [we] wish [the parties] to proceed." Inasmuch as the referenced evidentiary hearing pertained to an enforcement issue, we interpret claimant's May 20, 1999 letter as a request for enforcement of our February 11, 1999 order.[1]

We note that the record before us is inadequate to determine the enforcement issue. Thus, this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. Accordingly, this matter is referred to ALJ Johnson with instructions to conduct a fact finding hearing. ALJ Johnson shall take evidence concerning the insurer's alleged unreasonable refusal to pay compensation. ALJ Johnson shall issue recommendation making findings of fact on whether claimant is entitled to: (1) temporary disability benefits; and (2) penalties for the insurer's alleged unreasonable refusal to pay compensation. Based on those findings of fact, ALJ Johnson shall recommend to us whether we should find claimant entitled to temporary disability benefits and penalties. Following receipt of ALJ Johnson's recommendation, we shall implement a briefing schedule, and, upon its completion, proceed with our review.[2]

IT IS SO ORDERED.

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[1] In a separate action, we have begun the process of reviewing the insurer's May 19, 1999 closure.

[2] We acknowledge that the hearing convened before ALJ Johnson on April 26, 1999 could serve as the evidentiary hearing and request that he issue his Own Motion recommendation based on the testimonial and documentary evidence submitted at that hearing.

In the Matter of the Compensation of
PATRICK T. DAGGETT, Claimant
Own Motion No. 99-0193M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys
John Hayenga, Defense Attorney

The insurer has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on September 13, 1995.

The insurer recommends that we authorize the payment of temporary disability compensation under claimant's 1989 claim. Claimant has also filed an "occupational disease" claim for his right knee condition with the same employer/same insurer. (Claim No. 604578385). He has requested a hearing from the "occupational disease" carrier's responsibility denial. (WCB Case No. 99-04067). In addition, claimant has requested the issuance of a ".307" order.

Relying on *Leslie D. Marcum*, 50 Van Natta 2242 (1998), the parties agree that claimant's claim should be reopened under ORS 656.278. In *Marcum*, we authorized reopening of a claimant's own motion claim when the same insurer did not oppose reopening under ORS 656.278 but contested its responsibility for the claimant's "new injury" claim. In *Marcum*, we noted that, where there are available "administrative" remedies we generally postpone own motion action until exhaustion of those administrative procedures. OAR 438-012-0050. For example, when responsibility for a claimant's condition is the only issue which is contested, the matter is generally referred to the Department for a designation of a paying agent pursuant to ORS 656.307. *James D. Ortner*, 49 Van Natta 257 (1997); OAR 438-012-0032(3).

Here, although responsibility is being contested under the "occupational disease" claim, the insurer has accepted responsibility in the 1989 own motion claim. Additionally, the language of ORS 656.307(1)(a) and OAR 436-060-0180 indicates that the statute and rule apply when there is a responsibility issue involving "more than one insurer" or "two or more employers." By its terms, therefore, ORS 656.307 does not apply to a dispute involving only one insurer of one employer. Because this case does not involve a responsibility dispute among two or more employers and/or insurers, it does not fall within the parameters of the statute. *See James M. Van Natta*, 50 Van Natta 2104 (1998). Thus, claimant is unable to avail himself of the administrative remedies allowed under that statute and OAR 436-060-0180.

Here, as previously explained, the insurer is not contesting the compensability and/or responsibility of claimant's current right knee condition as it relates to the 1989 own motion claim. Additionally, the insurer acknowledges that surgery is appropriate for the compensable condition. In fact, the insurer recommends that we authorize reopening of claimant's own motion claim. Thus, there are no issues in the own motion claim for which claimant would need to avail himself of "administrative remedies."

Under these particular circumstances, and consistent with the *Marcum* rationale, we decline to postpone action on the own motion claim pending resolution of claimant's litigation of a responsibility issue regarding his current condition under an "occupational disease" claim. Consequently, we proceed with our review.

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

We are persuaded that claimant's current condition (for which the insurer has accepted responsibility under the 1989 claim) constitutes a worsening of his 1989 compensable injury that requires

surgery.[1] 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.

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[1] This conclusion is based on the presumption that the insurer, under the 1989 claim, will ultimately be held responsible for claimant's condition. In the event that the insurer is ultimately found responsible for claimant's current condition under his "occupational disease" claim, the insurer and/or claimant may request reconsideration of this decision under OAR 438-012-0065(3) at that time. *See Marcum*, 51 Van Natta at 2242.

July 16, 1999 Cite as 51 Van Natta 1278 (1999)

In the Matter of the Compensation of
JERRY W. LASHER, Claimant
WCB Case No. C991595
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Allison Tyler, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Bock and Phillips Polich.

On March 17, 1998, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

The first and fourth page of the proposed CDA provides that the total consideration due claimant is $1,500 and the total due claimant's attorney is $500, which equals a total consideration of $2,000 (page 4, line 1). However, the total recited in the body of the CDA, (page 3, line 5), is given as $501.50. Thus, the lone reference on page three of the document to a total consideration of $501.50 appears to be an error. Accordingly, we interpret the agreement as providing for a total consideration of $2,000, minus a $500 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 $500, 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
ERIC HALL, Claimant
WCB Case No. 97-05512
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In February 1997, claimant began working for the employer, a temporary services agency. (Tr. 9). He was assigned to two jobs before beginning work at a remill business on March 5, 1997. (Tr. 10-11, 82). Claimant performed different jobs at the remill business, including sawing, gathering and stacking wood, and cleanup activities. (Tr. 12, 79). He testified that the amount of time he spent stacking and gathering wood as opposed to sawing was "very close." (Tr. 13). Claimant said that he would often be moved to three or four different jobs a day and usually when was working on a saw, he would be there "at least maybe" half the day. (*Id.*)

Claimant testified that approximately one week to one and one-half weeks after working for the remill business, he felt numbness, tingling and stiffness in his right arm and forearm. (Tr. 36-42, 80). He began waking up at night because of the symptoms. (Tr. 36, 41). He started having left arm symptoms about two weeks after the right arm symptoms began. (Tr. 80, 81). Claimant's last day of work at the remill business was March 28, 1997. (Tr. 81).

On April 1, 1997, claimant sought treatment from Dr. Jansen for right arm pain. (Ex. 2). Dr. Jansen reported that claimant had developed symptoms approximately two weeks ago, while working at the remill business. (*Id.*) She diagnosed possible thoracic outlet syndrome, right forearm tendinitis and neck/shoulder strain/sprain. (*Id.*) Although Dr. Jansen could not rule out carpal tunnel syndrome, she doubted it could be caused by work at the employer because of his short employment. (*Id.*) Dr. Jansen treated claimant on three other occasions through April 28, 1997. (Ex. 5). On April 7, 1997, Dr. Jansen reported that claimant had not worked since the last visit except for reading in the office, but he had developed left arm symptoms. (Ex. 5-1). She noted that it was unusual to develop left arm symptoms without activities. (*Id.*) On April 28, 1997, Dr. Jansen reported that claimant had not worked lately and his hand symptoms were gradually improving. (Ex. 5-3).

Claimant was treated by Dr. Wilson on May 9, 1997. Dr. Wilson reported that claimant had gone back to work as a landscaper and his symptoms started getting worse. (Ex. 5-4). On May 16, 1997, Dr. Wilson recommended testing to rule out carpal tunnel syndrome (CTS). (Ex. 5-5). Dr. Jansen performed nerve conduction studies and diagnosed bilateral CTS. (Ex. 7). On June 30, 1997, claimant saw Dr. Wilson because of increasing pain in both wrists. (Ex. 10). Dr. Wilson noted that "[d]espite doing easier work for the last two months as a landscaper, the patient's symptoms progressively worsened." (*Id.*) He diagnosed mild CTS, right greater than left. (*Id.*)

On June 23, 1997, claimant was examined by Dr. Podemski on behalf of the employer. (Ex. 8).

On June 30, 1997, the employer denied the claim on the basis that claimant's work activities with the employer were not the major contributing cause of his condition. (Ex. 9).

Claimant was examined by Dr. Jewell on September 3, 1998. (Ex. 13). Dr. Jewell reported that claimant had worked for the remill business for two months when he developed hand and arm complaints. (Ex. 13-1). He diagnosed bilateral CTS and probable tenosynovitis. (Ex. 13-2).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Jewell's opinion and concluded that claimant's work activities at the employer were the major contributing cause of his bilateral CTS. The employer argues that Dr. Jewell's opinion is not persuasive because it is not well-reasoned and is not based on an accurate history. For the following reasons, we agree with the employer.

To establish an occupational disease, claimant must prove that his employment conditions were the major contributing cause of his bilateral CTS. 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). Because of the multiple possible causes of claimant's disability or need for treatment, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

There are four medical opinions on causation. In evaluating the medical evidence, 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). Here, we find no persuasive reason not to defer to Dr. Jansen, who treated claimant on four occasions.

On claimant's first visit to Dr. Jansen on April 1, 1997, she reported that claimant had developed symptoms approximately two weeks ago, while working at the remill business. (Ex. 2). Although Dr. Jansen could not rule out carpal tunnel syndrome, she doubted it could be caused by work at the employer because of claimant's short employment there. (*Id.*) Dr. Jansen subsequently agreed with Dr. Podemski's conclusion, noting that "working for approximately two weeks is too short to call carpal tunnel syndrome solely caused by that work activity." (Ex. 11). Dr. Jansen commented that claimant's work activities varied and there were a few days he did not work. (*Id.*)

Dr. Podemski reported that claimant worked in the mill for about two weeks when he began having symptoms in his hands. (Ex. 8-1). Dr. Podemski felt that was an "unlikely length of time" to develop CTS to claimant's present magnitude. (Ex. 8-4). He believed that claimant's CTS was idiopathic or multi-factorial. (Ex. 8-4, -5). Dr. Podemski noted that claimant's work in the mill may have been a contributing factor, but it was not the major or material contributing factor to developing CTS. (Ex. 8-5).

Claimant relies on the opinion of Dr. Jewell to establish compensability. Because Dr. Jewell examined claimant on only one occasion, his opinion is not entitled to any deference as a treating physician. Moreover, for the following reasons, we find that Dr. Jewell's opinion is based on an inaccurate history.

Dr. Jewell reported that claimant had worked for the employer for two months when he developed hand and arm complaints. (Ex. 13-1). Claimant told him he used his right hand to operate the chop saw and his left to operate the fancy saw. (*Id.*) Dr. Jewell indicated that claimant's work as a landscaper did not materially hurt his hands, although he noted that squeezing a pencil caused numbness in the right hand. (Ex. 13-2). Dr. Jewell found no evidence of swelling in either hand. (*Id.*) He diagnosed CTS and probable tenosynovitis and he concluded that claimant developed CTS while working for the remill business. (*Id.*) Dr. Jewell said that "[i]f the history as supplied by the claimant is accurate with respect to hand swelling and stiffness, this may be an explanation as to why he became symptomatic so quickly during his work at [the remill business]." (*Id.*) Dr. Teal agreed with Dr. Jewell's report. (Ex. 14).

At a deposition, Dr. Jewell said that he understood claimant worked with the saws on a daily basis and those activities were his primary job function. (Ex. 15-8, -9, -15, -16). Claimant testified, however, that he performed different jobs at the remill business, including sawing, gathering and stacking wood and cleanup activities. (Tr. 12, 79). He said the amount of time he spent stacking and gathering wood as opposed to sawing was "very close" and he would often be moved to three or four different jobs a day. (Tr. 13). When claimant worked on a saw, he would be there "at least maybe" half the day. (*Id.*) We find that Dr. Jewell's understanding of claimant's work activities is inaccurate.

Furthermore, Dr. Jewell did not have an accurate history of the onset of claimant's symptoms. Dr. Jewell believed that claimant had been performing sawing activities for two months before the onset of his symptoms. (Exs. 13-1, 15-9). In contrast, claimant testified that he felt numbness, tingling and stiffness in his right arm and forearm approximately one week to one and one-half weeks after working for the remill business. (Tr. 36-42, 80). When Dr. Jewell was asked to assume that Dr. Podemski had a correct history that claimant worked for only two weeks before developing symptoms, Dr. Jewell responded:

> "I think in this situation, which is a hypothetical, you are asking me if the claimant had worked two weeks, would this be a work-related process, and the answer would be this would not be a work-related process.
>
> "In other words, I would agree with Dr. Podemski that the claimant most likely had a preexisting carpal tunnel syndrome, because two weeks of employment would, generally speaking, not produce electrical findings of this magnitude." (Ex. 15-16, -17).

On the other hand, Dr. Jewell felt that one month of employment would be enough if claimant developed swelling and stiffness in his hands that caused CTS. (Ex. 15-25). He believed that claimant had an episode of tenosynovitis, which was evidenced by claimant's swelling and stiffness. (Ex. 15-25, -39). Dr. Jewell reported that claimant had hand swelling, which preceded his complaints of numbness. (Ex. 15-10, -15). Dr. Jewell believed that claimant's work at the remill business made his hands begin swelling, feeling stiff and then going numb, but when he was away from that activity, his hands improved after a month or so. (Ex. 15-30).

Claimant did not describe any symptoms of swelling at hearing and the medical records do not document any hand or arm swelling. Rather, claimant's testimony and the medical records indicate that he had experienced numbness, tingling, stiffness and pain. Dr. Jewell found no evidence of swelling in either of claimant's hands during his examination. (Ex. 13-2). Because Dr. Jewell's understanding that claimant had swelling is not supported by the record, we do not find his opinion persuasive.

Dr. Jewell understood that claimant's work as a landscaper did not bother his hands, although he felt it was inconsistent that claimant said that squeezing a pencil caused him some problems. (Ex. 15-18, -19, -30, -34). Claimant's last day of work at the remill business was March 28, 1997. (Tr. 81). On May 9, 1997, Dr. Wilson reported that claimant had gone back to work as a landscaper and his upper arm symptoms started getting worse. (Ex. 5-4). Dr. Jewell's understanding that claimant's work as a landscaper did not bother his hands is inconsistent with Dr. Wilson's report. Moreover, Dr. Jewell acknowledged that two months as a landscaper could cause abnormal electrical findings. (Ex. 15-20).

In sum, we are not persuaded that Dr. Jewell had an accurate history of claimant's work activities or the onset of his symptoms. Because it is based on a inaccurate history, Dr. Jewell'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). For the same reasons, we are not persuaded by Dr. Teal's concurrence with Dr. Jewell's report. When presented with an accurate history of claimant's symptoms, Dr. Jewell's opinion does not support compensability. (Ex. 15-17). We conclude that claimant has failed to establish that his work activities were the major contributing cause of his bilateral CTS.

ORDER

The ALJ's order dated February 19, 1999 is reversed. The self-insured employer's denial of claimant's bilateral carpal tunnel syndrome is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
PHILLIP A. OBRIST, Claimant
WCB Case Nos. 98-01136, 98-01134, 97-09618, 97-09617 & 97-06467
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scheminske, et al, Defense Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the Cigna Insurance Company's (Cigna's) denial of his current low back condition. The employer[1] cross-requests review of those portions of the ALJ's order that: (1) found that Cigna was responsible for claimant's current right shoulder condition; (2) set aside Cigna's denial of claimant's left shoulder condition; and (3) assessed a penalty against Kemper Insurance Company (Kemper) for its alleged delay in issuing a responsibility denial as to claimant's right shoulder claim. On review, the issues are compensability, responsibility and penalties.

We adopt and affirm the ALJ's order with the following change and supplementation. In the second paragraph on page 5, we change the first sentence to read: "The August 1997 coccyx/neck injury claim was closed by means of a February 1998 Determination Order that provided for temporary disability from August 2, 1997 through January 14, 1998."

Current Low Back Condition

We adopt and affirm the portion of the ALJ's order that concluded that claimant's current low back condition is not compensable. We write to address claimant's argument that there was no preexisting low back condition and he need only prove that the August 1997 work injury was a material contributing cause of his low back condition.

After claimant's August 1, 1997 injury, Cigna accepted a coccyx contusion and mild cervical strain. (Ex. 88). The claim was closed by means of a February 1998 Determination Order that did not award any permanent disability. (Ex. 116). On February 2, 1998, Cigna denied claimant's current condition, stating that the accepted condition was no longer the major contributing cause of the current condition and need for treatment or disability. (Ex. 110).

Claimant argues there is no evidence in the record to establish that he had a preexisting condition that impacts the analysis of the August 1, 1997 injury claim. We disagree.

The medical record indicates that claimant was diagnosed with degenerative disc disease in the lumbar spine in 1977. In August 1992, Dr. Vigeland had reviewed claimant's previous medical records and reported that he had low back pain with radiation into his legs in July 1977. (Ex. 45-1). Claimant's orthopedic surgeon at that time believed he had intervertebral disc disease with recurrent sciatica. (*Id.*) Dr. Vigeland concluded that claimant had suffered from longstanding mild disc degeneration since 1977. (Ex. 45-2).

On December 30, 1991, claimant sustained a low to mid-back injury at work. (Exs. 39, 40). Dr. Vigeland reported that when he examined claimant in March 1992, claimant had "indicated that he had had chronic, intermittent, low back discomfort for years." (Ex. 45-1). On May 18, 1992, Dr. Phipps reported that claimant had experienced "chronic pain with his back over many years," so he did not think much of the December 1991 injury at the time. (Ex. 43). However, claimant's back pain had been increasing and he had a gradual onset of symptoms in his feet and legs. (*Id.*) On July 17, 1992, Dr. Rosenbaum performed surgery for a central and left L4-5 disc herniation. (Ex. 44). The compensability of the 1991 low back and leg injury was resolved by means of a disputed claim settlement involving Cigna. (Ex. 46).

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[1] The carrier's brief indicates that the employer bears all financial risks involved in this case and one attorney represents the interests of Cigna Insurance Company and Kemper Insurance Company.

Claimant testified that he eventually returned to his regular duties after the July 1992 back surgery. (Tr. 47). For about six years after the surgery, claimant said he had no problems other than stiffness and soreness, except for a period when he had some epidural steroid injections. (Tr. 48). Dr. Norris reported that claimant had a series of epidurals from February 1996 to February 1997. (Ex. 93).

On August 1, 1997, claimant fell backwards onto his buttocks and struck his head at work. (Exs. 74, 76). Dr. Norris diagnosed a neck and low back strain and contusion, as well as coccydynia. (Ex. 77). Claimant was also treated by Drs. Grossenbacher and Rosenbaum. (Exs. 83, 84). Dr. Rosenbaum reported that an MRI did not demonstrate "significant" pathology. (Ex. 89). Similarly, Dr. Grossenbacher found that there was no essential change on the MRI from 1996 and he did not believe claimant was a surgical candidate. (Ex. 92). Dr. Keenan did not find a substantial change between the 1996 and 1997 MRI scans. (Ex. 125). In his reports, Dr. Norris referred to claimant's "chronic back pain from a previous injury exacerbated by an injury in August" (Ex. 93), and he commented in December 1997 that there was a "[r]elapse of acute back pain and spasm in a man with underlying disc disease." (Ex. 99).

On January 14, 1998, Drs. Bergquist and Strum examined claimant regarding his low back pain. (Ex. 105). They reviewed the October 1997 MRI and found degenerative changes at L2-3, L4-5 and L5-S1. (Ex. 105-5). They found significant inconsistencies in claimant's examination and determined that there were no objective findings that could be related to the August 1997 injury. (Ex. 105-5, -6). They concluded that any impairment was due to claimant's underlying degenerative lumbar disc disease. (Ex. 105-6). Dr. Norris agreed that claimant's objective findings were inconsistent and minimal, but he felt that claimant's subjective findings could be real. (Ex. 107).

Based on the foregoing medical reports, we conclude that claimant has had preexisting degenerative disc disease in his low back since 1977. In August 1992, Dr. Vigeland concluded that claimant had suffered from longstanding disc degeneration since 1977. (Ex. 45-2). Also in 1992, Drs. Phipps and Vigeland had referred to claimant's "chronic" low back condition. (Exs. 43, 45). Claimant had epidural steroid injections for back pain from February 1996 to February 1997. (Ex. 93). After the 1997 back injury, Drs. Grossenbacher and Keenen found no essential change in claimant's MRI scans since 1996. (Exs. 92, 125). Drs. Norris, Bergquist and Strum referred to claimant's underlying degenerative disc disease in his low back. (Exs. 99, 105). Similarly, Dr. Keenen also believed that claimant had a preexisting low back condition. (Exs. 125, 129). We conclude that claimant had preexisting degenerative disease in his low back and the medical reports support the conclusion that the August 1997 injury combined with the preexisting condition to cause or prolong disability or a need for treatment. The ALJ properly applied a major contributing cause standard under ORS 656.005(7)(a)(B). For the reasons discussed by the ALJ, we agree that claimant's current low back condition is not compensable.

Penalties

At hearing, claimant sought a penalty for Kemper Insurance Company's (Kemper's) delay in issuing a responsibility denial of claimant's right shoulder condition. The ALJ found that Kemper did not issue a denial for over six months. Because there was no explanation for the delay, the ALJ assessed a penalty against Kemper for its delay in issuing a responsibility denial as to claimant's right shoulder.

On August 8, 1997, claimant requested that Kemper accept claimant's right shoulder claim for own motion relief. (Ex. 78). Kemper issued responsibility denials of claimant's right shoulder condition on February 23, 1998. (Exs. 117, 118). An order designating a paying agent under ORS 656.307 did not issue until May 6, 1998. (Ex. 125A).

The employer argues that claimant failed to prove that any compensation was due to him under the own motion claim at the time Kemper denied responsibility. The employer contends that no penalty is authorized because no compensation is due until the claim is authorized to be reopened by the Board in its own motion jurisdiction.

The employer's argument misses the mark. The Board's own motion jurisdiction does not come into play under the facts in this case. The basis of the ALJ's penalty assessment is Kemper's failure to timely deny responsibility, which unreasonably delayed compensation that would have been payable under ORS 656.307, *not* under the Board's own motion jurisdiction. *See SAIF v. Moyer*, 63 Or App 498, 503, *rev den* 295 Or 541 (1983); *Elliott v. Loveness Lumber Co.*, 61 Or App 269, 272 (1983). Thus, the penalty against Kemper is not dependent on any compensation owed by Kemper on claimant's own motion claim.

In *SAIF v. Whitney*, 130 Or App 429 (1994), the court upheld the assessment of penalties against two insurers, although only one was responsible for the claim. The court concluded that the language of *former* ORS 656.262(10)(a) did not indicate that the legislature intended to limit the total amount of penalties that could be awarded. *Id.* at 432. Rather, the statute limited only the total amount of penalties that could be awarded against any one carrier. The court reasoned: "[i]f two insurers, or for that matter, four insurers, act unreasonably, we see no reason why they should not each be liable for a penalty of up to 25 percent." *Id.*

Former ORS 656.262(10)(a) has since been amended and renumbered to ORS 656.262(11)(a). Nevertheless, the language the court relied on in *Whitney* remains in the current version of the statute. ORS 656.262(11)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due."

Based on *SAIF v. Whitney*, although Kemper has not been found responsible for claimant's right shoulder claim, we must address whether Kemper is liable for a penalty for unreasonable delay in processing the claim. *See, e.g., Jon O. Norstadt*, 50 Van Natta 2416 (1998).

On August 8, 1997, claimant requested that Kemper accept claimant's right shoulder claim for own motion relief. (Ex. 78). Kemper issued responsibility denials of claimant's right shoulder condition on February 23, 1998. (Exs. 117, 118). An order designating a paying agent under ORS 656.307 did not issue until May 6, 1998. (Ex. 125A). As the ALJ noted, Kemper offered no explanation for the delay in issuing a denial. We find that Kemper did not accept or deny the claim within 90 days as required by ORS 656.262(6)(a). Under these circumstances, we conclude that Kemper unreasonably delayed processing the claim. We conclude that a penalty for unreasonable conduct may be assessed against Kemper, although no amounts are due under the claim against it. *See SAIF v. Whitney*, 130 Or App at 432. We agree with the ALJ's conclusion that a penalty of 25 percent of amounts due claimant (from Cigna) is appropriate.

Attorney Fee

Claimant's attorney has submitted an affidavit in support of an attorney fee, requesting an attorney fee of $750 for services on review regarding the right shoulder responsibility denial and $750 for services on review regarding the left shoulder compensability denial.

At hearing, the ALJ awarded claimant's attorney a fee of $1,000 under ORS 656.308(2)(d) for prevailing against Cigna's responsibility denial of the right shoulder condition. We agree with the employer that, under ORS 656.308(2)(d), the $1,000 limit applies to the case as whole, not to each level of litigation. Except in cases involving "extraordinary circumstances," ORS 656.308(2)(d) limits claimant to a maximum cumulative attorney fee of $1,000 for services at all levels of litigation. *Liberty Northwest Insurance Corp. v. Gordineer*, 150 Or App 136, 141 (1997); *Tammy Locke*, 48 Van Natta 250 (1996). The ALJ did not find any "extraordinary circumstances" and, after reviewing the record, we are unable to find that extraordinary circumstances exist which justify a fee greater than $1,000. We agree with the employer that claimant is not entitled to an additional attorney fee regarding the right shoulder responsibility denial.

Claimant's attorney is entitled to an assessed fee for services on review regarding the left shoulder conditions. 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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 18, 1999 is affirmed. For services on review regarding the left shoulder compensability denial, claimant's attorney is awarded $750, payable by the employer.

In the Matter of the Compensation of
JAMES M. OTTEN, Claimant
WCB Case No. 98-03691
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of his occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the exception of the second full paragraph on page 3, with the following supplementation.

Claimant, age 44 at the time of hearing, has worked for the employer, a produce wholesaler, since 1985. He drove semi trucks delivering produce until August 1996. This job initially entailed the use of a handtruck with a brake to carry sacks and boxes of produce down a ramp to unload the truck. In August 1996, claimant began working as a hostler, pulling out and backing in the trucks, which required vigorous turning of the steering wheel.

In late 1994 or early 1995, claimant started noticing hand symptoms, including numbness of the three fingers on the right side of his right hand. On October 2, 1995, claimant treated with Dr. Melvin for complaints of numbness in two fingers of the right hand. Melvin diagnosed right ulnar nerve entrapment at the elbow (cubital tunnel syndrome). Dr. Gerry performed nerve conduction studies of the ulnar and median nerves, which were normal. On November 13, 1995, the insurer accepted right cubital tunnel syndrome. Based on his clinical findings, Melvin performed an ulnar nerve release at the cubital tunnel on January 16, 1996.

Postoperatively, claimant reported improvement in sensation of the involved fingers, but also intermittent episodes of numbness in the fingers that spread over the back of the hand when physically active. He also reported pain in the palm and wrist of his right hand.

On January 7, 1997, Dr. Button performed a closing examination, in which Melvin concurred. Button reported that claimant did not complain of carpal tunnel symptoms, noting that the prior nerve conduction studies had been normal. A February 21, 1997 Determination Order closed the claim with an award of temporary disability only.

On June 30, 1997, medical arbiter Dr. Witczak, osteopathic hand surgeon, noted complaints of right hand pain, numbness (but less than previously) of four fingers of the right hand, and occasional radiating tingling into the fingers, as well as some symptoms in the left hand. Witczak found a positive Tinel's over the median and ulnar nerves at the right and left wrists and elbows, and a positive Phalen's on the right. He diagnosed recurrent right cubital tunnel syndrome and right median nerve neuritis and recommended repeat nerve conduction studies of the median and ulnar nerves. A July 8, 1997 Order on Reconsideration affirmed the Determination Order in all respects.

On December 12, 1997, claimant sought evaluation of wrist and palm pain, primarily on the right, by Dr. Long. Long diagnosed ulnar neuropathy at the right elbow, and median compression neuropathy in the palms, right greater than left. Long referred claimant to Dr. Hill for bilateral carpal tunnel surgery.[1]

On March 16, 1998, Dr. Button evaluated claimant's hands. Button reported nonanatomic responses and concluded that claimant's present symptoms arose after his 1997 examination. Button opined that claimant did not have carpal tunnel syndrome and recommended additional nerve conduction studies, which were performed on June 8, 1998 by Dr. Gerry. The studies of the right and left median nerves were normal.

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[1] Dr. Hill filed an aggravation claim. At hearing, the parties agreed that the issue was compensability of the carpal tunnel syndrome.

On March 23, 1998, the insurer denied compensability of the carpal tunnel condition, 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 persuasively establishes that his work activity for the employer is the major contributing cause of his bilateral carpal tunnel syndrome. Like the ALJ, we find to the contrary.

Dr. Long opined that claimant's work as a truck driver prior to December 1996 and as a hostler from January 1997 through December 1997 was the cause of his bilateral CTS. Long's opinion regarding the right hand was based on claimant's history of right hand numbness and pain beginning in 1993. (*See, e.g.*, Exs. 15-1, -5, 25-1, 28-31). In his deposition, however, Dr. Long acknowledged that Dr. Melvin's diagnosis of claimant's 1995 symptoms in the ulnar nerve distribution was correct. In support of his own view, Long hypothesized that Melvin had ignored claimant's median nerve symptoms, especially in light of Dr. Gerry's normal nerve conduction studies. Long also stated that Dr. Gerry's nerve conduction studies did not rule out the presence of median nerve involvement, as they had also been normal for the ulnar nerve, and if Gerry had performed the studies differently, he would have found a median nerve lesion. Because Long's opinion is based on an incorrect history and is unsupported by the contemporary medical reports (we do not find his hypotheses regarding the unrecognized median nerve lesion persuasive), and does not offer a well-reasoned analysis regarding the relationship of claimant's CTS and his *work activities*, we are unable to conclude that claimant's work activities were the major contributing cause of his right carpal tunnel syndrome. *Somers v. SAIF*, 77 Or App 259, 262 (1986).

Finally, in regard to the left hand, Long stated that "it is reasonable to *speculate* that left hand use *might* have increased as a complication of the development of right median and ulnar nerve lesions at the wrist and elbow." (Emphasis added). Medical possibility rather than medical probability is not persuasive. *Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive). Accordingly, Long's opinion regarding the cause of claimant's left carpal tunnel syndrome is insufficient to establish a compensable occupational disease.

In summary, in the absence of a persuasive medical opinion linking claimant's right and left carpal tunnel syndromes 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 March 4, 1999 is affirmed.

In the Matter of the Compensation of
DENNIS W. SHRUM, Claimant
WCB Case No. C991503
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On June 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 disapprove the proposed disposition.

A CDA 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 CDA was submitted to us on June 21, 1999. The statutory 30th day following the submission is July 22, 1999. On July 6, 1999, we received a letter from the SAIF Corporation indicating that the parties no longer wished to enter into the CDA. Accordingly, pursuant to the parties' request, we disapprove the CDA. *Id.*

Inasmuch as the proposed disposition has been disapproved, SAIF shall recommence payment of any temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(4)(i) and (6)(e).

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY J. RASMUSSEN, Claimant
WCB Case Nos. 98-02658 & 98-00670
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Kemper Insurance Company requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of compensability and responsibility for claimant's left knee condition; (2) upheld the SAIF Corporation's denial of the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1982 claim for his left knee with the SAIF Corporation. Although SAIF issued a Notice of Acceptance, it did not specify the condition accepted. In 1982 and again in 1983, claimant underwent surgery for the left knee.

In 1997, while working for Kemper's insured, claimant again injured his left knee. Kemper accepted a left knee strain. After medical evidence showed that claimant again required surgery for a degenerative condition, Kemper denied compensability and responsibility. SAIF denied responsibility.

The ALJ first found claimant's current left knee condition compensable. After further finding that the current left knee condition had not been previously accepted, the ALJ analyzed responsibility pursuant to *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984). Based on the medical evidence, the ALJ concluded that the 1997 injury causally contributed to the current left knee condition and, thus, Kemper could not shift responsibility back to SAIF.

Kemper challenges the ALJ's conclusion that it is responsible for the left knee condition. Specifically, Kemper asserts that we should apply *Conner v. B & S Logging*, 153 Or App 354 (1998), because the medical evidence shows that the SAIF claim was the major contributing cause of a consequential condition. We agree.

Conner involved a claimant who had an accepted 1985 claim with one carrier and a 1991 claim with a second carrier. The Board determined that the second carrier was responsible for the current condition claim (which had not been accepted) pursuant to *Kearns*. After finding that the medical evidence showed that the second injury was the major contributing cause of a portion of the current condition, and citing ORS 656.005(7)(a)(A), the court affirmed the Board's conclusion that the second carrier was responsible. 153 Or App at 162.

We applied *Conner* in *Michael C. Reddin*, 50 Van Natta 1396 (1998), and *Albert H. Olson*, 51 Van Natta 685 (1999). In *Reddin*, we found that the medical evidence did not show that either one of the claimant's prior accepted injuries alone was the major contributing cause of the current condition. Thus, the responsibility issue was decided under the last injury rule and rebuttable presumption in *Kearns*. 50 Van Natta at 1399.

In *Olson*, we further explained that we first determine whether the current condition has been previously accepted; if so, then responsibility is decided under ORS 656.308(1). If not, then responsibility is resolved under the *Kearns* presumption or ORS 656.005(7)(a)(A), depending on whether the medical evidence establishes that a prior accepted injury is the major contributing cause of a consequential condition. 51 Van Natta at 687. In that case, because the medical evidence showed that one of the accepted claims was the major contributing cause of the consequential condition, the carrier that accepted that claim was responsible for the current condition.

Because our first inquiry is whether the current left knee condition was previously accepted, it is necessary to determine what conditions were previously accepted. Claimant's current diagnosis is left knee end point arthritis of the medial compartment. (Exs. 65, 84-1). Because Kemper expressly accepted only a left knee strain, it did not accept the current left knee condition.

SAIF, however, did not accept a specific condition. Thus, we examine the record to determine what condition it accepted. Based on the record, we agree with the ALJ that SAIF accepted a torn medial meniscus. In this regard, claimant's treating surgeon, Dr. Peterson, diagnosed this condition following the 1982 work injury, and performed two surgeries for that condition. (Exs. 9, 13, 29). Although there is some indication that claimant was diagnosed with osteoarthritic changes in the medial compartment when his claim was closed for the second time (Exs. 38-2, 39), even if such condition was included within SAIF's scope of acceptance, there is no evidence that claimant had the current condition of end point arthritis. Consequently, we conclude that the current condition is an unaccepted condition. As such, ORS 656.308(1) does not apply in deciding responsibility.

Dr. Peterson is the only physician to provide an opinion concerning the cause of claimant's current left knee condition. Dr. Peterson first stated that the 1997 "injury in combination with pre-existing work related injuries" was the major contributing cause of claimant's current need for treatment. (Ex. 61). Dr. Peterson followed this statement with a report that "the major contributing cause of the combined condition were factors preceding the injury of April 24, 1997." (Ex. 62). Dr. Peterson next stated that claimant "now has end-stage medial compartment disease, which I feel is due to his original injury of 7/19/82[.]" (Ex. 65).

Dr. Peterson's subsequent report explained that claimant's 1997 left knee injury "did combine with the pre-existing condition" and that claimant "had preexisting chondromalacia of the medial compartment which was exacerbated by the April 24, 1997, injury." (Ex. 71). The report further stated that claimant's "left knee condition that I treated in 1997 is the end state of the knee condition he had as a result of his 1982 injury" and the 1997 injury "contributed to worsening of his pre-existing condition but the majority of his need for further surgery is due to the marked pre-existing degenerative changes. In other words, his condition now is the end state of him having undergone previous meniscectomy and the cumulative ensuing wear." (*Id.*)

Dr. Peterson's final correspondence stated that the "June 1997 [surgery] should be considered related to the April, 1997 injury because the April injury caused the knee to become more symptomatic. The subsequent tibial osteotomy and the current status of the knee are primarily due to the arthritis preceding April, 1997." (Ex. 84-2) (Emphasis in original).

We find that Dr. Peterson's opinion shows that the major contributing cause of claimant's current left knee condition is the 1982 condition and subsequent surgeries. That is, according to Dr. Peterson, before the 1997 injury, claimant had a preexisting arthritic condition that resulted from his previous 1982 condition and surgeries. We further understand Dr. Peterson as indicating that any contribution from the April 1997 injury to the current condition was only material. Thus, we conclude that the current left knee condition is a compensable consequential condition under ORS 656.005(7)(a)(A). *See Robert A. Willenberg*, 51 Van Natta 643, 647 (1999) (when current condition is a consequence of the compensable condition and resulting surgeries, it is compensable under ORS 656.005(7)(a)(A)).

Because the medical evidence shows that SAIF's accepted claim is the major contributing cause of claimant's current consequential condition, we further conclude that SAIF is responsible for claimant's current left knee condition. *Conner*, 153 Or App at 162; *Albert H. Olson*, 51 Van Natta at 691.

Attorney Fees

Kemper denied compensability and responsibility and SAIF denied only responsibility. Although we have found SAIF responsible for the current left knee condition, Kemper is liable under ORS 656.386(1) for the attorney fee awarded at hearing. *See Safeway Stores, Inc. v. Hayes*, 119 Or App 319 (1993) (court upheld assessment of fee under former ORS 656.386(1) against carrier that necessitated a claimant's participation to establish the compensability of the claim even though that carrier was not ultimately responsible).

After considering the factors set forth in OAR 438-015- 0010(4) and applying them to this case, we find that the ALJ's award of $2,800 was reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Thus, we affirm the ALJ's attorney fee award of $2,800, payable by Kemper.

Furthermore, claimant's attorney is entitled to a fee under ORS 656.308(2)(d) for prevailing against SAIF's responsibility denial 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 SAIF. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997).

ORDER

The ALJ's order dated February 1, 1999 is reversed. Kemper's denial of compensability and responsibility is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. Kemper is liable for the ALJ's $2,800 attorney fee award. For prevailing against SAIF's responsibility denial, claimant's attorney also is awarded an assessed fee of $1,000, to be paid by SAIF.

July 16, 1999 Cite as 51 Van Natta 1289 (1999)

In the Matter of the Compensation of
ADRIN F. STOCKS, Claimant
Own Motion No. 66-0463M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On July 6, 1999, the SAIF Corporation submitted claimant's request for medical benefits relating to his compensable August 6, 1962 injury. SAIF recommends reopening of this claim under our own motion specifically for reimbursement of home health care services provided prior to his entering a nursing home facility in January 1999.

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).

Accordingly, we find that the requested medical services were reasonable and necessary and causally related to the compensable injury. Therefore, we authorize SAIF's request for reimbursement for costs home health care provided prior to claimant's admittance to a nursing home facility.

This order shall supplement our April 30, 1999 order that previously reopened claimant's 1962 claim for the payment of medical services, specifically nursing home care and treatment, which were found to be reasonable and necessary and causally related to the compensable injury. After provision of the aforementioned medical services, the claim is again closed pursuant to OAR 438-012-0055.[1]

IT IS SO ORDERED.

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[1] SAIF noted in its request that claimant passed away on April 23, 1999.

In the Matter of the Compensation of
CLINT C. GRAHAM, Claimant
WCB Case No. 98-09738
ORDER OF DISMISSAL
Kryger et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Black's May 5, 1999 order. We have reviewed this request to determine if we have jurisdiction to consider this matter. Because the record does not establish that the Board received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On May 5, 1999, the ALJ issued an order that decreased claimant's unscheduled permanent disability from 15 percent, as awarded by an Order on Reconsideration, to 7 percent.

On June 2, 1999, claimant wrote to the ALJ requesting abatement and reconsideration of the ALJ's decision. The Hearings Division received the motion on June 9, 1999. On June 11, 1999, the ALJ sent a letter to counsel asking claimant's attorney to "submit any authority he can find concerning the validity of the Opinion and Order given that it was not correctly addressed to him" and giving the insurer's attorney an opportunity to respond.

By letter of June 14, 1999, claimant's attorney asserted that the motion for abatement and reconsideration was timely filed because it was mailed on June 2, 1999, as shown by an accompanying affidavit from his secretary. Alternatively, counsel contended that, because the order was incorrectly addressed to his office and he did not receive a copy until May 26, 1999, the ALJ should reissue a corrected order with new appeal rights.

On June 24, 1999, the ALJ wrote to counsel stating that, based on *Debby R. Coldiron*, 51 Van Natta 905, *on recon* 51 Van Natta 991 (1999), he was without jurisdiction to do anything else. On June 30, 1999, in response to further correspondence from claimant's attorney, the ALJ reiterated that the order's incorrect address to claimant's attorney "does not invalidate the order because the attorney is not a party" and "I no longer have jurisdiction of this matter."

On July 6, 1999, by certified mail, claimant requested review of the "Orders dated June 24, 1999 and June 30, 1999, issued by" the ALJ.

On July 8, 1999, the Board issued a computer-generated letter acknowledging receipt of claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

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

"Filing" of a request for review is the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. OAR 438-005-0046(1)(b). Failure to timely file the request for review requires dismissal of the request for review. *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992).

Here, the 30th day after the ALJ's May 5, 1999 order was June 4, 1999. The request for review was not mailed until July 6, 1999, more than 30 days after the ALJ's order. Consequently, claimant's request for review was not timely "filed" with the Board.

We note that claimant's request for review states that it appeals the "orders" dated June 24, 1999 and June 30, 1999. As explained above, the 30-day period to appeal the ALJ's May 5, 1999 order ended June 4, 1999. Consequently, by the time the ALJ sent his correspondence of June 24 and June 30, his order had become final by operation of law. Thus, as the ALJ correctly stated in his correspondence, he lacked authority to issue any further orders. *See Debby R. Coldiron*, 51 Van Natta at 905.

Accordingly, we dismiss claimant's request for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNON L. WHITE, Claimant
WCB Case No. C991600
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Mark W. Potter, Claimant Attorney
Neil W. Jones, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On June 29, 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 agreement provides that claimant will receive $17,925 and claimant's attorney will receive an attorney fee of $4,075, this equals a total consideration of $22,000. By handwritten revision, the attorney fee has been reduced to $3,325 (see page 3, number 13), thereby increasing the total amount due claimant to $18,675. This change was initialed only by claimant and claimant's attorney. However, the amount payable to claimant and claimant's attorney has not been revised on the first page of the document.

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 $22,000, with an attorney fee of $3,325 payable to claimant's attorney and $18,675 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' CDA is approved. An attorney fee of $3,325, 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
ALFRED L. HILLARD, Claimant
WCB Case Nos. 98-05142 & 98-02854
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Liberty Northwest Insurance Corporation requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its responsibility denial of claimant's "new injury" claim for a reherniated L5-S1 disk; and (2) upheld the SAIF Corporation's responsibility denial of the same condition. Claimant cross-requests review of that portion of the ALJ's order that awarded a $1,000 assessed attorney fee for claimant's attorney's services at hearing. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings with the following supplementation.

Claimant's attorney was instrumental in obtaining Liberty's concession regarding the compensability of claimant's disk reherniation.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's responsibility decision and supporting rationale.

Attorney Fees

The ALJ instructed Liberty to pay claimant's attorney a $1,000 assessed attorney fee for his services in resolving the responsibility dispute. On review, claimant asserts that "extraordinary circumstances" warrant a higher fee for his services at hearing, and he requests that the Board award a total fee of $3,000 for services at hearing and on review. Claimant also requests an additional $3,893.14 carrier-paid fee in regard to Liberty's pre-hearing acquiescence in the compensability of claimant's reherniated L5-S1 disk.[1] Liberty has not responded to claimant's attorney fee request in its brief on review.

We first note that claimant is not entitled to an assessed attorney fee for his counsel's services *on review* regarding the responsibility issue. Because the Department issued a "307 order" in this case, the authority for awarding an attorney fee is found in ORS 656.307. Pursuant to that provision, claimant is not entitled an assessed attorney fee for his counsel's services on review. *See* ORS 656.307(5); *Lynda C. Prociw*, 46 Van Natta 1875 (1994). Moreover, claimant is not entitled to an assessed fee for services on review under ORS 656.382(2). Claimant's right to compensation was not at risk of disallowance, because a "307 order" issued prior to hearing. And claimant's right to compensation was not at risk of reduction because the ALJ assigned responsibility to Liberty and it had the lowest rate of compensation. *See John H. Kirkpatrick*, 47 Van Natta 2105 (1995).

We turn to claimant's entitlement to an assessed fee for his services at hearing. As discussed above, this case arises under ORS 656.307, and the fee for services at hearing is authorized under ORS 656.307(5).[2] Pursuant to that provision, claimant is entitled to a reasonable fee for his counsel's appearance and active and meaningful participation at the hearing. Liberty does not assert that claimant's counsel's participation in the hearing was not active and meaningful. Consequently, claimant is entitled to an assessed fee under ORS 656.307(5).

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[1] Claimant requested this additional fee at hearing, but the ALJ did not award such a fee or otherwise address claimant's request.

[2] Because this case arises under ORS 656.307, the $1,000 attorney fee limitation set forth in ORS 656.308(2)(d) is not applicable, and claimant need not show extraordinary circumstances to obtain an increase in the assessed fee award. *See Dean Warren Plumbing v. Brenner*, 150 Or App 422 (1997).

Claimant is also entitled to an additional assessed fee under ORS 656.386(1). Pursuant to ORS 656.386(1)(a), a reasonable attorney fee shall be allowed in all cases involving "denied claims" where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. For purposes of this provision, "denied claims" includes a claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d), which the insurer or self-insured employer does not respond to within 30 days. ORS 656.386(1)(b)(B).

Claimant's reherniated L5-S1 disk is a "condition omitted from a notice of acceptance" because it was in existence at the time of SAIF's Notice of Acceptance.[3] ORS 656.262(6)(d); *Mark A. Baker*, 50 Van Natta 2333 (1998). Claimant's attorney requested an amended acceptance of the reherniated disk by letter dated February 27, 1998. Liberty did not respond to that request until July 2, 1998, at which time it conceded compensability and issued a denial of responsibility only. Meanwhile, on April 13, 1998, claimant's attorney filed a hearing request regarding Liberty's failure to issue a timely acceptance of claimant's reherniated disk. Liberty does not assert that claimant's attorney was not instrumental in obtaining its concession of the compensability of claimant's reherniated disk. Consequently, claimant is entitled to a reasonable assessed attorney fee under ORS 656.386(1).

We proceed to apply the factors in OAR 438-015-0010(4) to determine a reasonable assessed attorney fee regarding the compensability and responsibility issues. The record in this case includes 60 exhibits, and claimant's attorney generated the April 21, 1998 opinion letter from Dr. Amstutz. Claimant's attorney participated in a lengthy deposition of Dr. Amstutz that resulted in the opinion that persuasively resolved the responsibility issue. The hearing required several hours of travel and lasted two hours, including oral closing argument. The time devoted to the case was substantial, as demonstrated by claimant's counsel's statement of services for 31 hours of work prior to the ALJ's order.[4] The responsibility issue in this case was of average legal and medical complexity. The value of the claim and benefit secured are substantial in light of the nature of claimant's injury and his need for surgery.

After considering these factors, in particular the time devoted by claimant's attorney (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 regarding Liberty's concession of compensability and the "307" responsibility proceeding is $3,500.[5]

ORDER

The ALJ's order dated January 20, 1999 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant is awarded a $3,500 assessed attorney fee for his services at hearing, payable by Liberty Northwest Insurance Corporation. The remainder of the ALJ's order is affirmed.

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[3] Liberty's December 29, 1997 Notice of Acceptance issued after the herniation was confirmed by diagnostic studies performed on November 26, 1997.

[4] As discussed above, claimant is not entitled to an assessed fee for services on review regarding the responsibility issue.

[5] Claimant's attorney is not entitled to a fee for services on review regarding the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986); *Ernest C. Richter*, 44 Van Natta 101, *on recon* 44 Van Natta 118 (1992).

In the Matter of the Compensation of
ROSENDO M. VALENCIA, Claimant
WCB Case Nos. 97-07805 & 96-08301
ORDER DENYING RECONSIDERATION
Max Rae, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our June 24, 1999 order that affirmed the Administrative Law Judge's (ALJ)'s order awarding an attorney fee of $5,000 for services at hearing. In its motion, SAIF contends that the amount of the attorney fee award is excessive and, under the circumstances of the case, claimant's attorney should be awarded a fee of $2,000. Claimant responds that the attorney fee award is appropriate.

We find that our order adequately responds to SAIF's arguments. Accordingly, we deny SAIF's motion and we adhere to our June 24, 1999 order. The parties' rights of appeal shall continue to run from the date of that order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JON E. BALL, Claimant
WCB Case No. 99-00312
ORDER ON RECONSIDERATION
Dean Heiling & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our June 22, 1999 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order setting aside an Order on Reconsideration that rescinded a Notice of Closure as prematurely issued. Specifically, claimant requests that we remand the case to the Appellate Review Unit for a medical arbiter's examination and a reevaluation of his permanent disability.

We reject claimant's request for two reasons. First, claimant did not raise remand/extent of disability issues at hearing.[1] Thus, we are not inclined to address them. *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). Second, we have no authority to remand to the Department for a medical arbiter's examination. See *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993); *Patricia A. Brown*, 48 Van Natta 1164 (1996); *Linda M. Cross*, 45 Van Natta 2130 (1993).[2]

Accordingly, we withdraw our June 22, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our June 22, 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] While claimant alleged in his request for review that he should be awarded permanent disability, remand/extent of disability issues were not raised before the ALJ.

[2] In *Brown*, where the parties raised permanent disability as an issue before the ALJ, we remanded the matter to the ALJ to await the Department's appointment of an arbiter and the parties' submission of the arbiter's report. 48 Van Natta at 1166. *See also Dennis R. Loucks*, 50 Van Natta 1779 (1998). However, unlike *Brown*, the parties here did not raise extent of disability before the ALJ. Accordingly, we do not remand to the ALJ for deferral of an extent of disability issue pending receipt of an arbiter's report.

In the Matter of the Compensation of
BRADLEY A. PATTERSON, Claimant
WCB Case No. 98-09868
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

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

Applying ORS 656.005(7)(a)(B), the ALJ set aside the insurer's December 10, 1998 denial of claimant's current "combined" thoracic condition. In so doing, the ALJ found the medical opinions of claimant's attending physicians, Drs. Carvalho and Rheaume, who opined that claimant's compensable July 22, 1998 injury was the major contributing cause of claimant's need for treatment, more persuasive than the contrary opinions of examining physicians, Drs. Radecki and Fuller.

On review, the insurer contends that the record contains no evidence that, as of December 10, 1998, claimant's thoracic strain was the major cause of any need for treatment or any disability. Specifically, the insurer asserts that neither Dr. Carvalho nor Dr. Rheaume recommended any treatment after December 9, 1998 and that, therefore, they were only addressing treatment and/or disability that had occurred prior to that date. Thus, the insurer argues that their medical opinions cannot establish the compensability of the combined condition as of the date of the December 10, 1998 denial.[1] We disagree.

Dr. Carvalho stated on December 9, 1998 that no further medical follow-up was scheduled (Ex. 87-3). Dr. Rheaume, however, confirmed on March 9, 1999 that claimant continued to receive palliative care, albeit on an as-needed basis. (Ex. 87A-2). Therefore, we conclude that the record establishes that claimant had a need for treatment after December 10, 1998. Moreover, we are not persuaded that both physicians merely addressed claimant's need for treatment prior to the December 10, 1998 denial.

On December 22, 1998, Dr. Carvalho opined that "the July 22, 1998 industrial injury *is* the major contributing cause of [claimant's] current thoracic condition and need for treatment." (Ex. 87-1), emphasis added). Later on March 8, 1999, Dr. Carvalho reiterated that claimant's compensable injury "*is* the major contributing cause of [claimant's] current thoracic condition and need for treatment." (Ex. 90, emphasis added). Finally, Dr. Rheaume confirmed on March 9, 1999 that "[t]he accident of July 22, 1998 *is* close to 85% to 90% responsible for [claimant's] need for treatment." (Ex. 91-2, emphasis supplied).

Accordingly, we conclude that the ALJ properly set aside the insurer's denial. Thus, we affirm.

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

ORDER

The ALJ's order dated April 12, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[1] Claimant asserts on review that the ALJ improperly determined that the insurer's denial was procedurally valid. We do not address this issue because, even assuming that the ALJ's determination was correct, we nevertheless conclude that the insurer's denial should be set aside on the merits.

In the Matter of the Compensation of
LLANCE A. PETERSON, Claimant
WCB Case No. 98-07078
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its allegedly "de facto" denial of claimant's "new medical condition" claim for water retention and weight gain; and (2) awarded claimant's counsel an attorney fee pursuant to ORS 656.386(1) for prevailing over the denial.[1] On review, the issues are scope of acceptance and attorney fees.

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, concerning the scope of acceptance 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.[2]

ORDER

The ALJ's order dated December 31, 1998 is affirmed. For services on review, claimant's counsel is awarded $1,000, payable by the SAIF Corporation.

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[1] We treat SAIF's submission of the transcript of its closing argument as further argument supplementing its appellant's brief.

[2] 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 review concerning the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233.

In the Matter of the Compensation of
JAMES D. BOYLES, Claimant
WCB Case Nos. 98-08886 & 98-08363
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that set aside its denials of claimant's current condition and aggravation claims. On review, the issues are compensability and aggravation.

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

The insurer argues that the evidence does not support the ALJ's finding that claimant had intermittent pain in the posterior neck and right elbow following the 1994 injury. Instead, the insurer asserts that the evidence supports a conclusion that claimant was asymptornatic for three years after the injury.

Claimant testified that "the main bulk" of his pain "went away." (Tr. 11). The report of examining physicians Woodward and Farris stated that claimant has had "rather vaguely-described intermittent pain in the posterior lower aspect of the neck on the right side" and occasional aching in the right upper extremity on the medial aspect of the elbow. (Ex. 30-2). Based on this evidence, we do not find the ALJ's finding of intermittent pain to be unsupported. Rather, we find that claimant probably had some minor intermittent pain, but that most of the pain resolved after the 1994 injury.

The insurer asserts that Dr. Tearse's opinion is unpersuasive because it is based solely on elimination of other potential causes for claimant's symptoms which is prohibited by ORS 656.266. We disagree with the insurer in that we do not find Dr. Tearse's opinion to be based solely on an exclusion of other causes. Instead, we find, based on his opinion in Exhibit 36, that Dr. Tearse relied on his knowledge of the progression and symptoms of claimant's condition to determine its cause as well as diagnostic testing that eliminated other possible causes for the condition. Under such circumstances, we find that claimant's evidence goes beyond a mere chronological connection and does not implicate the prohibition in ORS 656.266. *See Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996).

Finally, the insurer argues that Dr. Tearse's opinion is insufficient to show an actual worsening of claimant's condition. However, Dr. Tearse agrees in Exhibit 25 that claimant's current condition is an actual worsening of his 1994 work injury and also agrees that this conclusion is supported by objective findings. Thus, we disagree with the insurer's argument and find sufficient evidence of an actual worsening.

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

ORDER

The ALJ's order dated February 12, 1999 is affirmed. For services on review, claimant's attorney is awarded $ 1,000, payable by the insurer.

In the Matter of the Compensation of
CHERYL A. MASSEY, Claimant
Own Motion No. 99-0223M
OWN MOTION ORDER OF DISMISSAL
Bischoff & Strooband, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted a request for temporary disability compensation for claimant's bilateral wrist condition. SAIF issued a denial of compensability of claimant's current condition. In addition, SAIF opposes the reopening of the claim on the grounds that: (1) SAIF is not responsible for the current condition; and (2) claimant is not in the work force.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

Here, claimant's claim was first closed on January 10, 1995. Claimant request reopening on March 10, 1995, prior to the expiration of his aggravation rights under ORS 656.273(4)(b). Additionally, Dr. Webb, claimant's attending physician, submitted his medical report recommending surgery approval for claimant's compensable condition on March 4, 1999. Following the submission of the chart note, on March 11, 1999, Dr. Webb completed and submitted to SAIF, a Notice of Claim Aggravation.

Under such circumstances, we requested the parties' positions regarding whether this claim was within our own motion jurisdiction pursuant to ORS 656.278. In response, SAIF acknowledges that claimant's aggravation rights were still in effect when it received the request for claim reopening. Consequently, SAIF withdraws the request for Own Motion relief.[1]

In light of SAIF's concession, we hold that claimant's aggravation rights have not yet expired under ORS 656.273(4). Rather, as implied by SAIF's recent submission, claimant's request for reopening will be processed as a claim for aggravation under ORS 656.273. Consequently, we do not have jurisdiction over this claim.

Accordingly, this request for claim reopening under ORS 656.278 is dismissed.

IT IS SO ORDERED.

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[1] Claimant responded to our inquiry contending that the request for Own Motion relief should be withdrawn because her aggravation rights had not expired at the time of the current worsening.

In the Matter of the Compensation of
CAROLYN ELLIOT, Claimant
Own Motion No. 98-0231M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on October 16, 1989. SAIF recommended against reopening on the grounds that: (1) surgery or hospitalization is not reasonable or necessary; and (2) claimant was not in the work force at the time of the current disability.

On June 16, 1998, we postponed action pending the outcome of the medical services dispute. By Administrative Order dated December 17, 1998, the Director found that the proposed surgery was appropriate for claimant compensable injury and ordered that SAIF "must pay for all costs associated with the provision of the disputed surgery." That order was not appealed, and has become final by operation of law.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Following the resolution of the medical services dispute, we requested the parties' positions regarding claimant's work force status. By letters dated April 1 and May 25, 1999, SAIF responded to our inquiry asserting that claimant "is not in the work force." On April 30, 1999, we granted claimant an extension of 30 days to afford her additional time to "document her work search efforts." To date, claimant has not responded to SAIF's submissions nor to our inquiry.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to her December 1997 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Claimant completed an Education/Work History Form sent to her by SAIF in April 1998. She listed, as part of her employment history for the last ten years, only one position which ended in June of 1983.

In April 1999, claimant was examined by an insurer-arranged medical examiner (IME) who reported that claimant had "essentially been without employment for the past ten years." In May 1999, claimant was referred to Dr. Long to assume the care and medical treatment for her compensable condition. Dr. Long observed that claimant had not work since November 1995.

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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).

Based on this record, we find that claimant has neither worked nor sought work since at least November 1995. In light of such circumstances, we conclude that claimant was not in the work force at the time of her current worsening. Consequently, we are not authorized to award temporary disability. Accordingly, claimant's request for temporary disability compensation is denied.[2] *See id.*

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

IT IS SO ORDERED.

[2] If claimant wishes to submit evidence demonstrating that she was in the work force at the time of her December 1997 disability, she is entitled to do so. However, because the Board's authority to reconsider its decision may expire within 30 days of the date of this order, it is recommended that any such evidence be submitted as soon as possible.

In the Matter of the Compensation of
MARTHA J. EBNER, Claimant
WCB Case No. C991657
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Steven M. Schoenfeld, Claimant Attorney
Sather, Byerly, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On July 6, 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 consideration due claimant is $375 and the total due claimant's attorney is $1,125. The body of the CDA, (page 3), provides a total consideration of $1,500 and that "out of the above consideration claimant's attorney would receive an attorney fee of $375. It is evident that the reference on the first page of the CDA to an attorney fee of $1,125" was a typographical error.[1] Accordingly, we interpret the agreement as providing for a total consideration of $1,500, $1,125 payable to claimant and $375 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 $375, 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.

[1] We note that a $375 attorney fee is consistent with OAR 438-015-0052(1).

In the Matter of the Compensation of
TONY D. HOUCK, Claimant
WCB Case No. 98-06681
Victor G. Tiscornia, Claimant Attorney
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) declined to take administrative notice of a Department order; and (2) determined that claimant's accepted conditions were prematurely closed. In its reply brief, the employer moves to strike portions of claimant's brief that refer to events outside the record. On review, the issues are administrative notice, motion to strike, premature closure and (potentially) extent of permanent disability. We affirm.

FINDINGS OF FACT

In July 1995, claimant filed a claim for bilateral upper extremity symptoms. (Ex. 8). On December 2, 1997, the employer accepted bilateral carpal tunnel syndrome (CTS) and left epicondylitis. (Ex. 39).

On September 9, 1997, Dr. McMahon examined claimant and reported that he continued to have paresthesias and weakness in his hands. (Ex. 33). He diagnosed bilateral CTS and referred claimant to Dr. Worland, who examined claimant on November 10, 1997 and recommended surgery for both wrists. (Ex. 36). On November 18, 1997, Dr. Worland took claimant off work because of constant pain, numbness and tingling in his hands. (Exs. 37, 38). Dr. Worland's work releases indicate he also examined claimant on December 2, 1997 and December 23, 1997. (Exs. 38, 40).

Dr. Jewell examined claimant on January 27, 1998 on behalf of the employer. (Ex. 41). He diagnosed musculoskeletal pain disorder, chronic, with associated mood and sleep disorder, and carpal tunnel-like symptomatology without evidence of objective confirmation. (Ex. 41-4). Dr. Jewell did not believe carpal tunnel surgery was reasonable or necessary. (Ex. 41-5). Dr. McMahon concurred with Dr. Jewell's opinion. (Ex. 42).

A Notice of Closure issued on March 12, 1998, awarding only temporary disability. (Ex. 45). Claimant requested reconsideration. (Ex. 47). Dr. Becker performed a medical arbiter examination on July 2, 1998. (Ex. 48). An Order on Reconsideration issued on July 30, 1998, changing claimant's temporary disability award, but otherwise affirming the Notice of Closure. (Ex. 49).

CONCLUSIONS OF LAW AND OPINION

Administrative Notice

The employer requested that the ALJ take administrative notice of proposed Exhibit 50, which is a November 16, 1998 administrative order from the Medical Review Unit of the Department of Business and Consumer Services (DCBS). The ALJ found that the issue in the administrative order was reasonableness of claimant's surgery, which was not relevant to the premature closure and/or extent issues before the ALJ. To the extent the administrative order was relevant, the ALJ found the exhibit was prejudicial and concluded that Exhibit 50 was inadmissible.

On review, the employer argues that the ALJ erred in denying the motion to take administrative notice of the November 16, 1998 order. As a general rule, the Board may take administrative notice of a fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2). In previous cases, we have taken administrative notice of agency orders involving the same claimant. *See, e.g., Janet R. Christensen*, 50 Van Natta 1152 (1998); *Brian M. Eggman*, 49 Van Natta 1835 (1997).

On the other hand, under ORS 656.283(7), we are statutorily prohibited in "extent" cases from considering "[e]vidence on an issue regarding a notice of closure or determination order" if that evidence was not submitted on reconsideration and made a part of the reconsideration record. *See, e.g., Precision Castparts Corp. v. Plummer*, 140 Or App 227, 231 (1996); *Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996).

In *Janet R. Christensen*, 50 Van Natta at 1152, the issue on review was the extent of the claimant's permanent disability. The claimant requested that we take administrative notice of our Order on Review that issued after the ALJ's order. We found that, because the Order on Review was not in existence at the time of the reconsideration proceeding, we could not consider it as evidence on any issue regarding the Notice of Closure. *Id.* at 1153. Nevertheless, we found that ORS 656.283(7) did not prohibit us from taking official notice of the fact that the claimant's stenosis and degenerative disc disease conditions were found compensable after the issuance of the Order on Reconsideration. *Id.* However, because taking administrative notice of our prior Order on Review had no impact on our rating of those conditions accepted at the time of closure (but was relevant to this case with regard to the procedure for processing and rating of conditions found compensable subsequent to claim closure), we granted the claimant's request. *Id.*

We may take administrative notice of agency orders involving the same claimant. The November 16, 1998 administrative order from the Medical Review Unit of DCBS is an act of a state agency, which is expressly subject to judicial notice under ORS 40.090(2).[1] The more difficult question, however, is whether we may consider the November 16, 1998 administrative order as evidence on an issue regarding the Notice of Closure and Order on Reconsideration. In *Christensen*, we took administrative notice of our Order on Review because it had no impact on our rating of those conditions accepted at the time of closure. Similarly, in *Eula M Zarling*, 50 Van Natta 1189, 1191 (1998), we took official notice of an Opinion and Order to clarify the scope and substance of the carrier's denials, but not for purposes of rating the claimant's accepted conditions.

Here, the November 16, 1998 administrative order determined that the bilateral carpal tunnel releases were not appropriate for claimant's compensable condition. That evidence was not submitted at the reconsideration proceeding. Unlike *Christensen* and *Zarling*, the medical treatment dispute decided by the November 16, 1998 order is relevant and could impact our decision about premature closure. *See Brian L. Schmitt*, 51 Van Natta 393 (1999). The employer asserts, and we agree, that the issues are interdependent.

Under 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[.]" In *Precision Castparts*, 140 Or App at 231, the court said:

> "The unmistakable import of the text of ORS 656.283(7) is that *any* evidence, including a claimant's own testimony concerning the notice of closure or reconsideration order, is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made part of the reconsideration record." (Emphasis in original.)

See also Rogue Valley Medical Center v. McClearen, 152 Or App 239, *rev den* 327 Or 123 (1998). Because the November 16, 1998 administrative order was not submitted at reconsideration and made part of the reconsideration record regarding the July 30, 1998 Order on Reconsideration, it is not admissible. The ALJ did not err in denying the employer's motion to take administrative notice of the November 16, 1998 order.

Motion to Strike

In its reply brief, the employer moves to strike portions of claimant's brief that refer to events outside the record.[2] We grant the employer's motion for the same reasons provided above and have not considered those portions of claimant's brief on review.

Premature Closure

The ALJ relied on Dr. Worland's opinion to conclude that claimant's CTS claim was prematurely closed. The ALJ also determined that claimant's left elbow epicondylitis condition was not medically stationary.

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[1] Under ORS 40.090(2), law judicially noticed is defined as "[p]ublic and private official acts of the legislative, executive and judicial departments of this state, the United States, and any other state, territory or other jurisdiction of the United States."

[2] Specifically, the employer moves to strike page four, note 1 of claimant's brief.

The employer argues that claimant did not affirmatively prove that his accepted conditions were not medically stationary. The employer contends that the reports of Drs. Jewell, McMahon and Baker are more persuasive than Dr. Worland's opinion.

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 employer has prematurely closed this claim depends on whether claimant was medically stationary at the time of the 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 a preponderance of 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 accepted conditions are bilateral CTS and left epicondylitis. (Ex. 39). The March 12, 1998 Notice of Closure found that claimant's conditions were medically stationary on January 27, 1998. (Ex. 45).

Although claimant signed a "change of attending physician" form on September 8, 1997 designating Dr. McMahon as his attending physician (Ex. 34), Dr. McMahon examined claimant on only one occasion before referring him to Dr. Worland. (Ex. 33). Dr. Worland initially examined claimant on November 10, 1997. (Ex. 36). On November 18, 1997, Dr. Worland took claimant off work. (Exs. 37, 38). Dr. Worland's work releases indicate that he also examined claimant on December 2, 1997 and December 23, 1997. (Exs. 38, 40). We agree with the ALJ that Dr. Worland was claimant's attending physician at the time of closure.

On November 18, 1997, Dr. Worland reported that claimant had constant pain, numbness and tingling in his hands. (Ex. 37). He found that claimant had a positive Tinel's sign, compression test, Phalen's test and reverse Phalen's test, and also had abnormal two-point discrimination, as well as weakness. (Exs. 36, 37). Dr. Worland noted that claimant had not responded to splinting or nonsteroidal anti-inflammatories over a two year period. (Ex. 37- 1). He diagnosed "electrically silent" CTS and recommended surgery for both wrists. (Ex. 36).

In a March 13, 1998 report,[3] Dr. Worland explained that it was a well-known fact among hand surgeons that "probably 10% of the time studies are normal although the patient does have carpal tunnel." (Ex. 46-1). Dr. Worland noted that claimant had a trial steroid in injections beneath the transverse carpal ligament with complete resolution of symptoms, which he explained was "completely diagnostic" of CTS. (*Id.*) He also relied on the fact that claimant had a positive Tinel's sign and Phalen's test, and also had objective findings of prolonged two-point discrimination. (Ex. 46-1, -2).

The employer argues that the reports of Drs. Jewell, McMahon and Becker are entitled to more weight than that of Dr. Worland. Dr. Jewell examined claimant on one occasion and diagnosed musculoskeletal pain disorder, chronic, with associated mood and sleep disorder, and carpal tunnel-like symptomatology without evidence of objective confirmation. (Ex. 41-4). Nevertheless, he reported evidence of a bilaterally positive Phalen's and Tinel's sign at the level of the transverse carpal ligament. (Ex. 41-3). Dr. Jewell said that non-nerve conduction test-proven CTS was an "exceedingly rare entity." (Ex. 41-4). Dr. Jewell did not believe carpal tunnel surgery was reasonable or necessary. (Ex. 41-5). He felt that claimant had a chronic musculoskeletal pain disorder rather than any type of compressive neuropathy and he believed there was an element of secondary gain with apparent symptom magnification. (*Id.*) Dr. McMahon, who had examined claimant on one occasion, concurred with Dr. Jewell's opinion. (Ex. 42).

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[3] The ALJ noted that Dr. Worland's March 13, 1998 report had not been considered by the Appellate Reviewer. The ALJ found that Dr. Worland's report had been submitted at hearing without objection and was appropriately part of the record. *See Fister v. South Hills Health Care*, 149 Or App 214, 218-19 (1997) (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 inadmissible), *rev den* 326 Or 389 (1998). The employer does not challenge this finding on review.

Dr. Becker performed a medical arbiter examination on July 2, 1998. (Ex. 48). He diagnosed "[n]umbness and pain in both wrists and left elbow, of unknown etiology, without current, clinical findings of carpal tunnel or lateral epicondylitis in the left elbow." (Ex. 48-4). Dr. Becker found that Tinel's testing was inconsistent on the median nerves, but was repetitive on the ulnar nerves at the elbow. (Ex. 48-3). Claimant had complaints of tingling in all fingertips with Phalen's tests. (*Id.*) He found that claimant's two point discrimination was normal. (Exs. 48-5). Dr. Becker did not believe there would be any beneficial expectations from carpal tunnel surgery. (Ex. 48-6).

At the time of closure, Dr. Worland was the physician who was primarily responsible for the treatment of claimant's compensable conditions. *See* ORS 656.005(12)(b). We find Dr. Worland's opinion to be based on accurate and complete information and supported by a well-reasoned explanation of the need for treatment. Although claimant had normal electrical studies, Dr. Worland explained that probably 10 percent of the time electrical studies are normal, but the patient does have CTS. (Ex. 46-1). Dr. Worland noted that claimant had a trial of steroid injections beneath the transverse carpal ligament with complete resolution of symptoms, which he explained was "completely diagnostic" of CTS.[4] (Ex. 46-1).

Unlike Drs. Jewell, Becker and McMahon, who each examined claimant on one occasion, Dr. Worland had the opportunity to observe claimant's condition over a period of time. Based on Dr. Worland's opinion, we agree with the ALJ's conclusion that claimant has carried his burden of proving that his CTS condition was not medically stationary when his claim was closed. Although the employer argues that claimant's left epicondylitis was medically stationary at the time of closure, claimant must be medically stationary with respect to all compensable conditions on January 27, 1998, the date his claim was closed.[5] *See Rogers v. Tri-Met*, 75 Or App 470 (1985).

Extent of Permanent Disability

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

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 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated January 21, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the self-insured employer.

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[4] In July 1995, due to the degree of claimant's problems and his lack of response to medication, Dr. Gulick had administered steroid injections and restricted claimant to modified work. (Exs. 12, 13). By August 29, 1995, Dr. Gulick reported that claimant had "significant improvement" after the injections and he released claimant to full work duty. (Ex. 15).

[5] We note that the employer is not precluded from reclosing the claim and including the November 16, 1998 administrative order as part of any future reconsideration record. *See Brian L. Schmitt* 51 Van Natta at 393.

In the Matter of the Compensation of
SAMUEL V. BILTON, Claimant
WCB Case No. 98-05678
ORDER ON REMAND
G. Joseph Gorciak III, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's July 7, 1999 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Disputed Claim Settlement Agreement" to resolve claimant's left upper extremity condition claim raised by his petition for judicial review of the Board's February 26, 1999 order.

According to the settlement, the parties agree that "the denial issued by the employer/administrator dated August 21, 1998, as amended herein, shall forever remain in full force and effect." The agreement further provides that it "disposes of all issues and claims raised or raisable" between the parties and that the "Request for Hearing thereon shall be dismissed with prejudice as to all issues and claims[.]"

We have approved the parties' agreement, thereby fully and finally resolving the parties' dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed.

IT IS SO ORDERED.

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[1] We note that one provision states that the settlement, "along with a General Release, Voluntary Termination and Settlement Agreement * * *, contains the entire agreement between the parties[.]" Because our authority is limited to consideration of the disputed claim settlement, this order does not extend to any agreement between the parties concerning claimant's employment status.

July 21, 1999 Cite as 51 Van Natta 1305 (1999)

In the Matter of the Compensation of
RANDY P. NUNN, Claimant
WCB Case No. 98-09410
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that reduced an Order on Reconsideration award of 26 percent (83.2 degrees) unscheduled permanent disability for his low back injury to zero. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ found no medical evidence sufficient to support an award of permanent disability. On review, claimant asserts that the physical capacities evaluation (PCE), which was concurred in by Dr. Kitchel, his attending physician, provides medical evidence of valid range of motion findings in his lumbar spine, in contrast to the arbiter panel's findings, and should be relied on. We disagree.

Contrary to claimant's argument, all of the physicians who may make findings of impairment have provided written opinions based on sound medical principles which explain why the findings of impairment are invalid. Specifically, the PCE evaluator noted:

> "[Claimant fails to meet straight leg raise validity criteria, which raises the question of full participation in flexion and extension, where he appeared to guard with lumbar range of motion, and we don't have confidence that these findings represent actual mobility of the lumbar spine.
>
> "[Claimant's] report is consistent with what we would anticipate he would be capable of doing at this point in time, however he fails to follow through during demonstration and begins to symptom magnify during the evaluation. This was noted with straight leg validity check, limitations in range of motion and a positive response to all Waddell's signs for non-organic pain behavior. He continues to participate in the evaluation while he reports pain that is disabling, another clear sign of symptom magnification." (Ex. 11-4).

The medical arbiter panel also found that claimant's impairment findings were invalid. Specifically, they stated "the examination throughout is carried out with a marked reaction on movement, simple touching of the back and gesturing and posturing of [claimant] throughout in a very overt fashion." (Ex. 22-1). They also noted that all lumbar range of motion measurements were "performed under marked subjective control." (Ex. 22-2). Finally, in response to the request that any

invalid findings be documented with the rationale and detailed reasoning, the arbiters stated, "[s]ince the findings are invalid based on give-way weakness and marked posturing and general behavior on the part of [claimant], this point must be stipulated." (Exs. 20-2, 22-1).

After our review, we find that the physicians who rated impairment determined that the findings were invalid and provided written opinions, based on sound medical principles, explaining why the findings were invalid. Under such circumstances, we disagree with claimant's assertion that the impairment findings concurred in by Dr. Kitchel prove a level of impairment different from that found by the arbiters.

ORDER

The ALJ's order dated March 29, 1999 is affirmed.

In the Matter of the Compensation of
RAYMOND ALDINGER, Claimant
Own Motion No. 89-0334M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Linerud Law Firm, Attorneys

Claimant requests review of the self-insured employer's December 30, 1998 Notice of Closure which closed his claim with an award of temporary disability compensation from January 23, 1993 through November 15, 1998. The employer declared claimant medically stationary as of November 16, 1998. Claimant contends that he is entitled to additional temporary disability benefits because he was not medically stationary when his claim was closed.

In a March 3, 1999 letter, we requested the employer to submit copies of materials considered in closing the claim. Upon the employer's submission of these materials, claimant was allowed 15 days to submit additional materials. The employer submitted its response on March 15, 1999. Claimant has not submitted a response to the employer'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 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 30, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On November 16, 1998, claimant was examined by an insured-arranged medical examiner (IME), Dr. Hodgson. He reported that claimant was in need of repair of an eardrum perforation in the form of a tympanoplasty. This recommended surgery could mildly improve claimant's hearing loss. However, Dr. Hodgson opined that the eardrum perforation was "not a direct result of any injury sustained in the motor vehicle accident from 1982." With regard to claimant's compensable ear injury, Dr. Hodgson opined that there was no further curative treatment necessary and that he was medically stationary. On December 27, 1998, Dr. Epley, claimant's attending physician, concurred with Dr. Hodgson's report. These opinions are unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary when his claim was closed. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the insurer's January 25, 1995 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
AMMER A. ALEXANDER, Claimant
Own Motion No. 66-0063M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On May 13, 1999, we issued an Own Motion Order on Reconsideration, which authorized the reopening of claimant's December 3, 1954 neck injury claim with the SAIF Corporation for the provision of medical services in the form of housing in an assisted living residence. In addition, we directed that claimant's claim remain open until medical services are no longer required.

On May 27, 1999, SAIF submitted claimant's request for additional medical benefits relating to his claim. SAIF recommended reopening of this claim under our own motion authority to provide continued care in a housing facility until modifications to a rental home are completed and claimant moves in. SAIF also requests authorization for reimbursement of the cost of: (1) remodeling of the rental home as necessary; (2) the provision of prosthetic devices such as, but not limited to, a hospital bed and a wheelchair; and (3) live-in care provider to assist claimant. In addition, SAIF recommended that the claim remain open until medical services are no longer required.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, the Board has been granted own motion authority to authorize medical services for compensable injuries occurring before January 1, 1966. *See* ORS 656.278(1).

One of the objectives of the Workers' Compensation Law is to restore the injured worker physically and economically to a self-sufficient status to the greatest extent practicable. ORS 656.012. We note that the requested services will not completely restore claimant's self-sufficiency. Although he will be as self-sufficient as possible within the home, he will still require assistance in many areas of his life. However, the appropriate test for whether a medical service is reasonable and necessary is not whether claimant will continue to need the assistance of a caregiver. *SAIF v. Glubrecht*, 156 Or App 339 (1998); *Stoddard v. Credit Thrift Corporation*, 103 Or App 283 (1990). Rather, the test is whether the requested services are reasonable and necessary as required by the nature of the compensable injury. ORS 656.245.

Here, claimant was injured on the job and rendered quadriplegic. He was granted permanent total disability and since his wife passed away, requires attendants to care for him 24 hours a day. The modifications to the rental home are required to accommodate his wheelchair and other non-remodeling-related accommodations are required to assist with his everyday living and care. Hence, we find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, claimant's claim is reopened to provide the above medical services. *See* OAR 438-012-0037.

This order shall supplement our May 13, 1999 order that previously reopened claimant's 1954 claim for the payment of housing in an assisted living residence. Claimant's claim shall remain reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury. Authorization for these 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. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY S. DAVIS, Claimant
WCB Case No. 98-05387
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) upheld the self-insured employer's denial of his occupational disease/injury claim for low back disc herniations; and (2) upheld the employer's denial of his current low back condition. On review, the issue is compensability.

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

The ALJ upheld the employer's denial of claimant's alleged disc herniations at L4-5 and L5-S1. In doing so, the ALJ relied on the medical opinion of an examining neurosurgeon, Dr. Rosenbaum, who opined that claimant's employment activities in December 1997 did not cause symptomatic disc herniations at the disputed levels.

On review, claimant asserts that Dr. Rosenbaum's opinion is not persuasive because it is contradicted by the existence of symptoms that Dr. Rosenbaum testified were an indication of a herniated disc. In support of his argument, claimant cites the lower extremity symptoms mentioned in medical reports from Dr. Puziss, an examining orthopedist, Dr. Miller, a consulting neurosurgeon, and Dr. Sedgwick, an attending physician. For the following reasons, we do not find claimant's contentions persuasive.

Claimant did report lower extremity symptoms to Dr. Sedgewick that arguably were consistent with what Dr. Rosenbaum described as "classic" for a herniated disc. (Exs. 10, 32-5). However, there is substantial medical evidence that casts doubt on whether those symptoms were the result of herniated discs. For example, Dr. Miller reported that there was a "paucity" of neurological findings. (Ex. 14-3). Dr. Puziss also stated that there were "no neurological deficits or findings." (Ex. 26-5). Dr. Rosenbaum opined that claimant's lower extremity symptoms were not consistent with disc herniations at the disputed levels. (Ex. 32-9).

Based on our *de novo* review of the record, we are not persuaded the medical evidence sufficiently establishes that claimant's work activity was the major contributing cause of herniated discs at L4-5 and L5-S1. Therefore, we agree with the ALJ's decision to uphold the employer's denial.

ORDER

The ALJ's order dated February 22, 1999 is affirmed.

In the Matter of the Compensation of
LOUIS L. HARON, Claimant
Own Motion No. 66-0195M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 30, 1998 Notice of Closure, as amended on December 11, 1998, which closed his claim with an award of temporary disability compensation from January 8, 1990 through October 20, 1998. SAIF declared claimant medically stationary as of October 20, 1998. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDING OF FACTS

Claimant suffered a compensable low back injury in 1960. His claim was reopened in 1989 for lumbar surgery and temporary disability compensation. Claimant has undergone several surgeries to his back, the last one in 1993.

In 1994, Dr. Nash, claimant's treating physician, recommended further surgery for claimant's low back condition. Additionally, at that time, claimant sought treatment for a psychiatric condition which was felt to be related to his compensable low back injury. SAIF denied the psychiatric condition as compensable and opposed further surgery on claimant's back contending that such treatment was not medically appropriate for his current low back condition.

On June 4, 1996, we issued our Own Motion Order which set aside SAIF's denial of claimant's psychiatric condition and declined to authorize the requested medical services, specifically, the proposed osteostimulator implant or the fusion surgery at L3-4, as being neither reasonable nor necessary treatment for claimant's compensable condition. Dr. Noyes, claimant's attending physician, declared that claimant's compensable low back medically stationary as of June 30, 1997. Claimant's claim remain open however, because his now accepted psychiatric condition was not medically stationary.

In a check-the-box reply to SAIF's adjuster's inquiry, Dr. Anderson, claimant's attending psychiatrist, declared his mental condition as stable and medically stationary as of October 20, 1998. Based on Drs. Anderson's and Noyes' opinions, SAIF issued its November 30, 1998 Notice of Closure, which it amended on December 11, 1998.

On December 17, 1998, SAIF requested that we authorize reopening of claimant's claim to provide for "ongoing compensable medical services until there [sic] are no longer required."

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 November 30, 1998 Notice of Closure, as amended December 11, 1998, 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, SAIF relies on Drs. Noyes' and Anderson's opinions that claimant's compensable low back and psychiatric conditions are medically stationary. SAIF further relies on our June 4, 1996 Own Motion Order which found the recommended surgery for claimant's compensable low back condition as inappropriate treatment. However, our order and Dr. Noyes' report relates to claimant's low back condition as it existed in 1996 and 1997, over two years prior to the issuance of SAIF's November 1998 Notice of Closure.

At SAIF's request, in July 1998, Dr. Misko examined claimant. He reported claimant had a lumbar fusion in 1990 at L3-4 which was thought to be solid. However, over the years claimant had developed a clicking feeling and was unable to stand up straight or do any lumbar extension without severe back and bilateral leg pain. Dr. Misko reviewed recent MRI and flexion-extension films and noted that there was motion at L3-4 with facet hypertrophy and no evidence of any fusion between the transverse processes at L3 and L4. Further, a review of a recent CT scan clearly demonstrated that there was "not a solid fusion at [L3-4] and there is motion on flexion and extension." Dr. Misko recommended a L3-4 Ray cage fusion. On October 1998, Dr. Noyes concurred with Dr. Misko's findings and noted that claimant has had "progressive pain and problems and has not shown any pattern of improvement, only worsening."

SAIF also argues that we must not rely on Drs. Misko's or Nash's opinions because they are not members of the managed care organization (MCO). SAIF contends that, in MCO situations, claimant's medically stationary status must be declared by an MCO-approved physician. We disagree.

In deciding whether a claimant is medically stationary, we have previously relief on the opinions of non-MCO physicians when the record indicates that the physicians' opinions are well-reasoned and based on medical evidence. *See Orben Baldwin*, 48 Van Natta 1877 (1996); *Marsha Brown*, 47 Van Natta 1465 (1995). Here, Dr. Misko's opinion is based on a thorough medical examination and complete review of the medical record as well as recent diagnostic studies. Dr. Noyes has treated claimant for several years and is vastly familiar with claimant's medical history. He concurred with Dr. Misko's opinion that claimant's condition has progressively deteriorated and is in need for further surgery. These opinions are unrebutted.

Thus, we conclude that Dr. Misko's June 1998 report and Dr. Noyes' October 1998 concurrence, indicate that claimant's compensable condition worsened since first declared medically stationary in June 1997 and that with further surgery, there is a reasonable expectation of material improvement in claimant's low back condition. Inasmuch as both opinions were rendered shortly before claim closure, we do not find that claimant's compensable low back condition was medically stationary on November 30, 1998, the date of claim closure nor on December 11, 1998, when the closure was amended.

Accordingly, we set aside the November 30, 1998 Notice of Closure, as amended on December 11, 1998, as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.[1]

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

IT IS SO ORDERED.

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[1] In light of our finding that the claim was prematurely closed, we have dismissed SAIF's December 17, 1998 own motion recommendation in a separate order.

In the Matter of the Compensation of
SCOTT D. HYDER, Claimant
WCB Case No. 98-08529
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's scheduled permanent disability award for the loss of use and function of the right arm from 68 percent (130.56 degrees), as awarded by an Order on Reconsideration, to 99 percent (190.08 degrees). On review, the issue is extent of scheduled permanent partial disability (PPD). We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained multiple injuries as a result of a compensable motor vehicle accident in October 1996. The employer accepted, among other conditions, "right sided brachial plexus injury (which includes complete ulnar and partial median nerve palsy and radial nerve contusion)." Claimant's claim was closed by a May 14, 1998 Determination Order that awarded, *inter alia*, 65 percent scheduled permanent disability for the right arm. This award was increased to 68 percent by an October 5, 1998 Order on Reconsideration.

The sole issue before the ALJ was the calculation of claimant's award for loss of strength in his right arm. Relying on the *Guides to Evaluation of Permanent Impairment*, 3rd ed. (rev.), 1990, *see former* OAR 436-035-0007(18)(b),[1] to identify the spinal nerve roots that innervate the weakened muscles in claimant's right arm,[2] the ALJ awarded 99 percent scheduled permanent disability for the right arm.

The employer asserts that claimant's scheduled permanent disability award should be reduced to no less than 82 percent of the right arm. After review of the record, we recalculate claimant's scheduled permanent disability for loss of use or function of his right arm as follows.[3]

Because claimant sustained an injury to his brachial plexus, impairment for loss of strength is calculated pursuant to OAR 436-035-0110(9), which provides that loss of strength in the upper extremity secondary to an injury to the brachial plexus is determined pursuant to OAR 436-035-0110(7), as modified by OAR 436-035-0007(18). We accordingly apply the administrative rule and the *AMA Guides* to determine which spinal nerve roots were involved in the weakness found in the hand intrinsics (0/5), the triceps muscle (3/5), and the wrist flexors (4/5).

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[1] On review, the employer argues that the ALJ erred in his identification of the spinal nerve roots innervating claimant's weakened muscles. In support of its argument, the employer submitted an excerpt from *Gray's Anatomy*, Thirtieth American Edition. However, *former* OAR 436-035-0007(18)(b) provides that the "the peripheral nerve or spinal nerve root which supplies (innervates) certain muscles *may* be identified by referencing current anatomy texts *or* the *AMA Guides to the Evaluation of Permanent Impairment*, 3rd. Ed. (Revised), 1990 or 4th Ed., 1993" (emphasis added). Although we agree with the employer that we may refer to the current *Gray's Anatomy*, we find no reason not to use the *AMA Guides* in this case.

[2] The ALJ relied on Figure 46, "Brachial Plexus" on page 44; and Figure 47, "Motor Innervation of the Upper Extremity" on page 45.

[3] In rating claimant's PPD, we apply the "standards" set forth in WCD Administrative Order 97-072 (effective February 15, 1997), which were in effect at the time of the May 14, 1998 Determination Order. OAR 436-035-0003(2).

According to the *AMA Guides*,[4] the hand intrinsics are innervated by both the median and ulnar nerves of the plexus; the spinal nerve roots involved are C6, C7, C8 and T1. The triceps muscle is innervated by the radial nerves of the plexus; the spinal roots are C5, C6, C7, C8 and T1. The wrist flexors are innervated by the median and ulnar nerves; the spinal roots are C6, C7, C8, and T1.

When more than one muscle is innervated by the same nerve, the impairment in each muscle is averaged. OAR 436-035-0007(19). For the hand intrinsics, the multiplier is 100 percent (0/5); for the triceps, it is 50 percent (3/5); and for the wrist extensors, it is 20 percent (4/5). OAR 436-035-0007(18)(a). Using the ratings in OAR 436-035-0110(7), the calculations are as follows:

C5	Triceps	50% x 30%	=	15%	15%	
C5 Average						15%
C6	Triceps	50% x 35%	=	17.5%	18%	
	Hand	100% x 35%	=	35%	35%	
	Wrist	20% x 35%	=	7%	7%	
C6 Average						20%
C7	Triceps	50% x 35%	=	17.5%	18%	
	Hand	100% x 35%	=	35%	35%	
	Wrist	20% x 35%	=	7%	7%	
C7 Average						20%
C8	Triceps	50% x 45%	=	22.5%	23%	
	Hand	100% x 45%	=	45%	45%	
	Wrist	20% x 45%	=	9%	9%	
C8 Average						26%
T1	Triceps	50% x 20%	=	10%	10%	
	Hand	100% x 20%	=	20%	20%	
	Wrist	20% x 20%	=	4%	4%	
T1 Average						11%

When multiple nerves have impairment findings, the values are combined for an overall loss of strength value before combining with other impairment values. *Former* OAR 436-035-0007(20). Combining the average impairment in each muscle as listed above (26/20/20/15/11) results in a combined value of 64 percent.

The remaining unchallenged values are 66 percent lost range of motion in the hand, 8 percent lost range of motion in the wrist, and 5 percent for loss of repetitive use of the wrist/forearm, which are converted to 53 percent, 7 percent, and 4 percent of the arm respectively. *Former* OAR 436-035-0090. Claimant also has 5 percent loss of repetitive use of the arm. These values are combined with the value for loss of strength (64/55/7/5/4) for a total value of 86 percent scheduled permanent disability for the loss of use and function of the right arm. *Former* OAR 436-035-0007(17). Because claimant has already received 68 percent scheduled permanent disability for his right arm, he is entitled to an additional 18 percent scheduled permanent disability. Accordingly, the ALJ's additional award of 31 percent scheduled permanent disability is reduced to 18 percent.

ORDER

The ALJ's order dated February 19, 1999 is modified. In lieu of the ALJ's scheduled permanent disability award, and in addition to the Order of Reconsideration's award of 68 percent (130.56 degrees) scheduled permanent disability for loss of use or function of his right arm, claimant is awarded 18 percent (34.56 degrees) scheduled permanent disability, for a total of 86 percent (165.12 degrees) scheduled permanent disability for loss of use or function of his right arm. Claimant's counsel's "out-of-compensation" attorney fee award is modified accordingly.

[4] In addition to the figures relied on by the ALJ, we also rely on Table 9, "Origins and Functions of the Peripheral Nerves of the Upper Extremity Emanating from the Brachial Plexus (Cervical 5 to 8 and Thoracic 1)", page 40.

In the Matter of the Compensation of
MELVIN J. LUX, Claimant
Own Motion No. 99-0243M
OWN MOTION ORDER
Daniel J. De Norch, Claimant Attorney

The self-insured employer submitted claimant's request for temporary disability compensation for his compensable bilateral knee condition. Claimant's aggravation rights on that claim expired on March 13, 1994. The employer opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

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).

Here, the employer contended that claimant's failure to provide proof of earnings demonstrated that he was not in the work force. In response to the employer's contention, claimant has submitted a copy of his latest paystub which demonstrates that he was in the work force during the month of May 1999.[1] Based on claimant's submission, we find that he was in the work force at the time of his current worsening which required surgery.

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

IT IS SO ORDERED.

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[1] In a May 12, 1999 medical report, Dr. Baldwin recommended claimant undergo a total knee arthroplasty. 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, is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to May 12, 1999 when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

In the Matter of the Compensation of
JOSEPH D. PESTA, Claimant
WCB Case No. 98-08318
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) Livesley's order that awarded claimant 17 percent (54.4 degrees) unscheduled permanent disability for a left inguinal hernia injury, whereas an Order on Reconsideration awarded no permanent disability. 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 correction that the claim was closed by a May 28, 1998 (not July 30, 1998) Determination Order.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a left inguinal hernia resulting from a July 30, 1997 work accident. A May 28, 1998 Determination Order issued that awarded no permanent disability. The Order on Reconsideration affirmed that award.

Relying on the reports from Dr. Bascom, medical arbiter, the ALJ concluded that claimant was entitled to a 5 percent impairment value under OAR 436-035-0320(5), and awarded 17 percent unscheduled permanent disability for a left inguinal hernia condition.

The insurer disputes this conclusion, asserting that claimant has not established that there was permanent damage to the abdominal wall under OAR 436-035-0375(1), and, even if claimant can establish impairment, he is not entitled to a value for non-impairment factors because Dr. DeHaas, attending physician, released him to regular work. Claimant asserts that the most persuasive report of impairment is from the medical arbiter. Based on that report, claimant contends that the ALJ correctly determined the award of 17 percent unscheduled permanent disability.

In rating claimant's permanent partial disability, we apply the "standards" set forth in WCD Administrative Order 97-072 (effective February 15, 1997), which were in effect at the time of the May 28, 1998 Determination Order. OAR 436-035-0003(2). Because a medical arbiter panel was used, claimant's impairment is determined by the arbiters except where a different level of impairment is established by a preponderance of medical opinion from the attending physician or other physicians with whom the attending physician concurs. ORS 656.245(2)(b)(B); ORS 656.268(7); *former* OAR 436-035-0007(12) and (13); *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994).

Dr. DeHaas, attending physician, performed surgery to repair claimant's left inguinal hernia on March 11, 1998. On May 6, 1998, DeHaas filled out a form in which he indicated that he had last treated claimant on March 17, 1998, that he anticipated that claimant would become medically stationary on April 10, 1998, and that he released claimant to regular work on the same date. There is no information in DeHaas' treatment reports that he was aware of claimant's work duties, and he did not perform a closing examination.

Dr. Bascom, medical arbiter, examined claimant on September 22, 1998. Bascom based his impairment findings on the physical examination he performed that day, finding objective evidence of permanent nerve entrapment within the inguinal hernia repair. Bascom opined that surgery could possibly relieve claimant's discomfort, but without further treatment, claimant had permanent damage to the abdominal wall due to the left inguinal hernia. Bascom also evaluated claimant's former and present abilities to perform work, and placed permanent restrictions on claimant's lifting that necessitate a reduction in the strength/lifting category of the job that claimant was performing at the time of injury.

After reviewing the medical evidence, we find that Dr. Bascom provided the most thorough, complete and well-reasoned evaluation of claimant's permanent injury-related impairment. Accordingly, we rely on his report to establish impairment findings. *See Carlos S. Cobian*, 45 Van Natta 1582 (1993) (Board relies on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

Based on Dr. Bascom's report, we conclude that claimant has established a 5 percent impairment value under OAR 436-035-0375(1).[1]

The insurer also argues that claimant was released to perform his regular work and that, consequently, he should only receive an award for the impairment factor. ORS 656.726(3)(f)(D)(ii) provides in pertinent part: "(D) Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214(5) if ** * (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."

Here, even assuming that Dr. DeHaas released claimant to regular work at the job he held at the time of injury, there is no evidence that the remaining statutory requirements were fulfilled. Accordingly, claimant is entitled to a rating for non-impairment factors.

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

ORDER

The ALJ's order dated March 16, 1999 is affirmed. For services on review, claimant's attorney is awarded a fee of $750, to be paid by the insurer.

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[1] OAR 436-035-0375(1) provides: "For injuries that result in permanent damage to the abdominal wall, 5% impairment shall be allowed it the attending physician places permanent restriction(s) on the worker which necessitates a reduction in the strength/lifting category of the job that the worker was performing at the time of injury."

July 22, 1999 Cite as 51 Van Natta 1315 (1999)

In the Matter of the Compensation of
PHILLIP PARKER, Claimant
WCB Case No. C991692
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On July 13, 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 $22,500. Originally, the agreement provided that claimant would receive $17,625 and claimant's attorney would receive an attorney fee of $4,875 payable out of the CDA proceeds. By handwritten revision, the attorney fee has been reduced to $3,600, thereby increasing the total amount due claimant to $18,900. However, the amount payable to claimant's attorney in the body of the agreement (see page 3) has not been revised and still provides for a $4,875 attorney fee.

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 $22,500, with an attorney fee of $3,600 payable to claimant's attorney and $18,900 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 $3,600, 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
RAYMUN B. SAVALAS, Claimant
Own Motion No. 99-0173M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
William J. Blitz, Defense Attorney

The self-insured employer has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on June 9, 1986. The insurer opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant contends that he qualifies for temporary disability compensation because, although unable to work due to the worsening of his current condition, he has been seeking part-time employment. In support of his contentions, claimant submitted an unsworn statement and a concurrence report signed by Dr. Brewster, his attending physician. In response, the insurer contends that claimant's unsupported assertions are insufficient to establish his work force status.

The burden of establishing entitlement to compensation rests with claimant. ORS 656.266. Claimant must establish that he was in the work force at the time of his disability[1] and, pursuant to the *Dawkins* criteria above, must provide persuasive evidence that he was willing to work or to seek work at the time of disability.

Claimant's general statement that "it will be only part time work I will be looking for" is disputed. In response to the insurer's challenge, claimant provides no corroborating evidence supporting his statement that he has sought work (full or part-time) prior to the time his condition worsened requiring surgery. In the absence of corroborating evidence, we do not find claimant's challenged general assertions sufficient to establish that he was willing and seeking work at the time of his disability. *See Dawkins*, 308 Or at 258.

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[1] 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, is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to March 3, 1999 when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Further, the medical documentation contained in the record fails to establish that claimant was unable to work and that it would have been futile for him to seek work due to his compensable condition. In fact, Dr. Brewster reported that claimant was able to "at least seek part-time work."

Given the lack of evidence that he was either seeking work or unable to work at the time of disability, we find that claimant was not willing to work despite his statement to the contrary. *See Wausau Insurance Companies v. Morris*, 103 Or App 273 (1990).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNA F. THOMAS, Claimant
Own Motion No. 95-0456M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Popick & Merkel, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's March 18, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from June 24, 1997 through February 25, 1999. The insurer declared claimant medically stationary as of February 25, 1999. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 March 18, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In an April 28, 1999 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 last examined by Dr. Wright, her attending physician, on September 16, 1998. Following that examination, Dr. Wright completed a "check-the-box" letter wherein, in answer to the employer's question regarding claimant's medically stationary status, he replied "No * * * will not be medically stationary until 6/11/99." In a March 11, 1999 medical report, Dr. Wright reported that claimant was "doing well at this stage" and that he would expect her to be medically stationary in June 1999. Finally, in April 1999, Dr. Wright, in a response to a request from claimant's attorney, opined that when he last saw claimant in September 1998, she was "doing well and was improving slowly." He went on further to report that "[a]t that time I felt she would not be medically stationary until one year after the surgery. I continue to feel that this is the case, but will be unable to comment further on how she is doing until her next visit with me."

On February 25, 1999, claimant was examined by Dr. Nolan, who conducted an insurer-arranged medical examine (IME) and reported that no further surgical procedures on the hands or wrists are recommended or proposed. He opined that claimant could "be considered medically stationary." Relying on Dr. Nolan's conclusion, the insurer declared claimant medically stationary as of February 25, 1999 and closed her claim on March 18, 1999.

Claimant argues that because Dr. Wright is her attending physician, it is his opinion which should be relied on to determine her medically stationary status. She also contends that Dr. Wright's unwavering opinion that she would be medically stationary one year after her June 1998 surgery supports her contention that she was not medically stationary at the time her 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. Nolan, the IME doctor, provided a thorough analysis of claimant's current condition. He opined that, although vigorous use of her hands may result in further difficulty, her condition was stationary and there was no additional treatment indicated.

We find Dr. Nolan's opinion more persuasive than Dr. Wright's. In reaching this conclusion, we note that Dr. Wright last saw claimant in September, 1998. Although he did state that claimant was not stationary at that time, that opinion does not reflect claimant's medically stationary status when her claim was closed six months later. In addition, Dr. Wright did not explain his reasoning in his later reports for determining that claimant was not medically stationary.

In contrast to Dr. Wright, Dr. Nolan 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. Wright's opinion regarding claimant's medically stationary status at the time of closure more persuasive than Dr. Wright's unexplained opinion.

Based on the aforementioned 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. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's March 18, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHANTEL W. WEBB, Claimant
WCB Case No. 98-03388
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

FINDINGS OF FACT

Claimant has been employed as a guest services representative at the employer's hotel since 1995. On February 1, 1998, claimant injured her left knee while dancing at the employer's annual company party. As claimant was twisting in a squatting position, her left knee gave way and she experienced the sudden onset of left knee pain with subsequent swelling in that area. When claimant's condition did not resolve with conservative treatment, Dr. Dickinson performed arthroscopic left knee surgery on February 16, 1998. During the surgery, Dr. Dickinson removed multiple cartilaginous loose bodies and a large articular defect from the medial facet of the patella.

On March 3, 1998, claimant submitted a formal injury claim for her left knee condition, and the insurer denied the claim on March 16, 1998.

At the time of the February 1, 1998 injury, claimant had a preexisting malalignment of the left knee in relation to the hip and ankle, and a further malalignment of the left patella. Claimant had previously injured her left knee in an off-work incident in April 1997, when she was dancing and experienced the sudden onset of left knee pain. This prior injury resolved after a short period of physical therapy and pain medication.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that Dr. Dickinson's opinion established a compensable relationship between claimant's February 1, 1998 work incident and her current left knee condition. On review, the insurer contends that the ALJ's conclusion is not supported by the record. We agree.

The causation issue in this case is a complex medical question that must be resolved with expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). The only expert causation opinion is from Dr. Dickinson. He opined that claimant dislocated her left knee while dancing on February 1, 1998, and that fragments of articular knee cartilage probably broke loose at that time. Dr. Dickinson further opined that claimant's preexisting knee malalignment predisposed her to the knee dislocation, and that claimant's current left knee condition was the result of the combined effect of the preexisting malalignment and the dancing activity on February 1, 1998. Finally, Dr. Dickinson explained that the arthroscopic surgery removed the loose cartilage in claimant's knee but did nothing to correct the preexisting malalignment.

As claimant's injury claim is based on this opinion from Dr. Dickinson, she must establish that the February 1998 work incident is the major contributing cause of the disability or treatment associated with her combined left knee condition. ORS 656.005(7)(a)(B). The ALJ reasoned that this burden of proof was satisfied by Dr. Dickinson's opinion that the loosening of the articular cartilage at the time of the February 1998 work incident represented a worsening of claimant's preexisting knee condition. We disagree. A major causal relationship is not established by a worsening of a claimant's preexisting condition. Rather, the claimant must prove that work activity is the major cause of any worsening, as distinct from the precipitating cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev den* 321 Or 416 (1995).

Here, Dr. Dickinson did not opine that the February 1, 1998 dancing activity was the major cause of the loosened articular cartilage. To the contrary, he opined that claimant's own inherent anatomy was more important to causation than the activity she was participating in at the time of the injury, and that claimant's preexisting malalignment was the major contributing cause of her current condition and need for surgery and other treatment. In addition, Dr. Dickinson characterized the February 1998 dancing activity as a precipitating cause rather than a major cause. Specifically, Dr. Dickinson described the dancing activity as "the straw that broke the camel's back", and he opined that claimant's left knee was "an accident waiting to happen."

We have also considered Dr. Dickinson's statement that "the [dancing] probably (>50%) caused the cartilaginous loose bodies but the pre-existing condition would still be the major contributing cause of [the] need for treatment." We do not interpret the first part of this statement as an opinion that the dancing activity was the major cause of the loose cartilage. Rather, we read this statement in the context of Dr. Dickinson's opinion as a whole and conclude that he was explaining that the cartilaginous fragments probably broke loose at the time of the dancing incident.

In summary, for the reasons discussed above, we conclude that Dr. Dickinson's opinion does not satisfy claimant's burden of establishing a major causal relationship between the February 1998 dancing activity and her current left knee disability and treatment. Because the ALJ found to the contrary, we reverse.

ORDER

The ALJ's order dated March 24, 1999 is reversed. The insurer's March 16, 1998 denial is reinstated and upheld. The ALJ's assessed attorney fee award is reversed.

In the Matter of the Compensation of
LARRY L. BRILEY, Claimant
Own Motion No. 99-0263M
OWN MOTION ORDER
Industrial Indemnity, Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights expired on March 1, 1990. Although the insurer recommends authorization of temporary disability compensation, it reports that it is unknown whether claimant was in the work force at the time of his current disability.

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

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. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, the insurer contended that claimant's failure to provide proof of earnings made it unknown whether he was in the work force. In response to the insurer's contention, claimant has submitted copies of earnings statements which span a time period between January 1999 through June 1999. Based on claimant's submission, we find that he was in the work force at the time of his current worsening which required surgery.[1]

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

IT IS SO ORDERED.

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[1] In an April 26, 1999 medical report, Dr. Collis recommended that claimant undergo a total knee replacement and staple removal. 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, is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to April 26, 1999 when his condition worsened requiring 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).

In the Matter of the Compensation of
DARLA J. COX, Claimant
Own Motion No. 98-0226M
OWN MOTION ORDER ON RECONSIDERATION
Coughlin, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On May 19, 1998, the SAIF Corporation submitted claimant's claim for an alleged worsening of her November 16, 1992 compensable right hand and thumb conditions. Claimant's aggravation rights on that claim expired on November 16, 1997. SAIF recommended that the claim be reopened for own motion relief. On May 27, 1998, we issued our Own Motion Order, which authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. We also instructed SAIF to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

On June 24, 1998, SAIF requested that we withdraw our May 27, 1998 Own Motion order because claimant's current worsening "should have been processed as an aggravation versus own motion." We treat SAIF's request as a request for reconsideration.

In extraordinary circumstances, we may, on our own motion, reconsider a prior order. OAR 438-012-0065(2). Under the facts of this case (i.e. a "post-Own Motion Order" determination that the claim should have been processed as a claim under ORS 656.273), we find that extraordinary circumstances exist that justify reconsideration of our prior order. Therefore, we withdraw our prior order and issue the following order in its place.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

Here, SAIF contends that when claimant requested own motion relief for her current worsening, her aggravation rights had not yet expired under ORS 656.273(4). Consequently, we do not have jurisdiction over this claim.

In light of SAIF's unrebutted contention in this case, we conclude we are without authority to reopen claimant's 1992 claim. *See* ORS 656.278(1)(a). Instead, SAIF should process claimant's request as a claim for aggravation under ORS 656.273.

Accordingly, on reconsideration, we deny the request for own motion relief. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KARIN R. McKINNEY, Claimant
WCB Case No. 98-07775
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Bock, Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's current left knee and cervical conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant had no history of neck, upper back or knee problems prior to June 20, 1997, when she sustained a cervical strain and left knee contusion in a compensable motor vehicle accident (MVA). Claimant received ongoing conservative treatment for neck, upper back and left knee symptoms through early September 1997, when she moved to Washington state. Dr. Lewis, the treating orthopedic surgeon, performed a final examination on September 5, 1997. (Ex. 13). At that time, he reported continuing cervical symptoms and recommended that claimant seek further treatment from a physiatrist in Washington.

After claimant's move to Washington, she was evaluated by Dr. Gollogly, orthopedist, on November 4, 1997. Claimant told Dr. Gollogly that her knee condition had "cleared up," but that she had recently experienced a flare-up of neck and left scapula pain. Dr. Gollogly anticipated a resolution of claimant's symptoms with heat, rest, aspirin and time, and he recommended a follow-up visit in six to eight weeks. (Ex. 15).

Claimant went without further treatment until she was evaluated by Dr. Tomski, physiatrist, on May 26, 1998. Claimant continued treating with Dr. Tomski through August 28, 1998. During the course of his treatment, Dr. Tomski reported diverse subjective symptoms and findings, including: stress, tension and depression; pain, numbness and weakness in the fingers of both hands; pain in the head, neck, right shoulder, mid-back and low back; and hypertonus in the cervical/thoracic and lumbosacral spine, with tightness and muscle spasm. Dr. Tomski diagnosed severe cranial/cervical/thoracic/lumbosacral strain/dysfunction syndrome and stress/tension. (Exs. 18, 19, 20, 21, 24, 27).

On August 5, 1998, Dr. Schilperoort, orthopedic surgeon, examined claimant for the insurer. In his examination report, Dr. Schilperoort noted claimant's statement that her left knee problems completely resolved within six weeks of the June 1997 MVA and had not caused her any further discomfort. Dr. Schilperoort's examination findings included: pain on palpation of the neck and upper back; reduced cervical and shoulder motion; nonanatomical sensory testing in the left upper extremity; mild left knee tenderness on palpation; and hypesthesia along the lateral aspect of both thighs, stopping above the knee on the right and extending to the knee on the left. (Ex. 25).

On September 18, 1998, the insurer issued a denial of claimant's current cervical strain and left knee contusion conditions.

Claimant was evaluated by Dr. Woodward, orthopedic surgeon, on November 10, 1998. Dr. Woodward reported the following subjective symptoms and findings: pain in the neck, upper back, right shoulder and right arm; vague finger numbness on the right; occasional numbness in the left upper extremity; reduced cervical and bilateral knee motion; and frequent pain on the medial aspect of the knee, with stiffness, popping and weakness. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

There is no evidence in this record that claimant's current cervical and left knee problems are a "consequential condition" under ORS 656.005(7)(a)(A) or a "combined condition" under ORS 656.005(7)(a)(B). Rather, claimant asserts that her current problems are a continuation of her accepted MVA injuries, and therefore, has the burden of proving that the compensable MVA remains a material contributing cause of her current conditions. ORS 656.005(7)(a) and 656.266; *Fred Meyer, Inc. v. Crompton*, 150 Or App 531 (1997). The insurer contends that the ALJ erred in concluding that claimant has satisfied this burden of proof. We agree.

The causation issue in this case is complicated by the elapsed time since the MVA, the six-month break in treatment from November 1997 to May 1998, the diffuse nature of claimant's current complaints, and reports of nonanatomical sensory findings and other functional overlay. In addition, the medical experts have differing opinions regarding the causal relationship between claimant's current condition and the June 1997 MVA. Consequently, the causation issue must be resolved with expert medical opinion that is both well-reasoned and based on an accurate and complete history. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to do otherwise, we give deference to the opinion of a treating physician who has had the opportunity to evaluate a claimant over time. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, claimant's treating physicians disagree on the causation issue. Dr. Tomski opined that the compensable MVA "is the major contributing cause of [claimant's] need for ongoing treatment to her entire spine, to include her knee and lumbosacral condition." (Exs. 27, 34). Dr. Lewis (Ex. 33) concurred with the contrary opinion of Dr. Schilperoort (Exs. 25, 35, 36) and Dr. Woodward (Ex. 31) that claimant's current complaints are not related to the June 1997 MVA.

The ALJ deferred to the opinion of Dr. Tomski after concluding that the contrary medical opinions were unexplained and inconsistent with examination findings of reduced cervical motion and left knee tenderness. The ALJ also reasoned that Dr. Tomski's opinion was consistent with claimant's symptomatic history. In this regard, the ALJ relied on claimant's testimony that she had not been free of symptoms since the June 1997 MVA, that she had no prior neck or left knee problems, and that she did not receive treatment from November 1997 to May 1998 because she had difficulty finding a doctor who would treat an Oregon workers' compensation injury. (Tr. 27-28, 31-33; Ex. 25-2). In so doing, the ALJ found "no basis in this record to question claimant's credibility."

We are not persuaded that claimant's testimony of ongoing left knee symptoms is consistent with the documentary record. Dr. Schilperoort's August 1998 examination report notes claimant's statement that her left knee problems completely resolved within six weeks of the MVA. In addition, Dr. Lewis did not report left knee symptoms at his final examination in September 1997, and Dr. Gollogly reported in November 1997 that claimant's knee had "cleared up."

Furthermore, we find other persuasive reasons not to defer to Dr. Tomski's opinion. First, he did not treat claimant's left knee condition or even discuss her left knee symptoms and findings. Second, Dr. Tomski did not become the treating physician until late May 1998 and, thus, had no personal knowledge of claimant's condition following the June 1997 MVA. In contrast, Dr. Lewis' contrary opinion is based on his personal observation and treatment of claimant following the accident. Third, Dr. Tomski's opinion is conclusory. In particular, he did not discuss the possible significance of the six-month break in claimant's treatment or her documented report of the total resolution of her left knee complaints. In addition, Dr. Tomski did not explain the basis of his opinion that claimant's diverse symptoms were a continuation of the accepted cervical strain and left knee contusion. Finally, Dr. Tomski did not respond to Dr. Schilperoort's report of functional overlay, or his discussion of possible alternative causes, including postural aberrancies, deconditioning, depression or other psychological conditions.

In summary, for the reasons discussed above, we are not persuaded that claimant has carried her burden of proving that the June 1997 MVA continues to be a material contributing cause of her current cervical and left knee conditions. Consequently, we reverse the ALJ's decision that claimant has established a compensable claim for these conditions.

ORDER

The ALJ's order dated January 22, 1999 is reversed. The insurer's September 18, 1998 denial is reinstated and upheld. The ALJ's assessed fee award is reversed.

Board Member Phillips Polich dissenting.

I would affirm the ALJ's decision that claimant's compensable MVA remains a material contributing cause of her current cervical and left knee conditions. I agree that this case is complicated by claimant's nonorganic conditions and diffuse physical symptoms. Nevertheless, I do not find persuasive reasons not to defer to Dr. Tomski's opinion relating claimant's current condition to the compensable MVA. Thus, I respectfully dissent.

Dr. Tomski's opinion is supported by objective findings of reduced cervical motion and reproducible left knee pain, and he is the only medical expert with the opportunity to personally observe and evaluate claimant's current condition over time. Dr. Lewis last examined claimant in September 1997, and Drs. Schilperoort and Woodward examined claimant on only one occasion. Furthermore, as discussed by the ALJ, Dr. Tomski's opinion is consistent with claimant's testimony regarding her symptomatic history. Like the ALJ, I accept claimant's testimony of ongoing symptoms since the MVA, and no prior neck, back or left knee problems. Claimant's testimony that her left knee condition has waxed and waned explains why she reported a resolution of left knee symptoms to Drs. Gollogly and Schilperoort. Claimant's credible testimony also supports the ALJ's finding that the accepted condition worsened because claimant could not find a physiatrist in Washington who would treat an Oregon worker's compensation injury. That finding is also consistent with Dr. Lewis' recommendation of further treatment from a physiatrist, and Dr. Tomski's discussion of claimant's dissatisfaction with the limited treatment offered by Dr. Gollogly. Given this record, the six-month break in treatment is not a basis for denying compensability.

Moreover, I agree with the ALJ that the contrary medical opinions are unexplained and inconsistent with the examination findings. Dr. Lewis' opinion is nothing more than a conclusory concurrence. Dr. Woodward did not explain the basis for his conclusion that the injury-related left knee contusion and cervical strain had resolved without impairment. Nor did he provide an alternative explanation for claimant's continued left knee pain and reduced cervical motion. Dr. Schilperoort did not explain why he concluded that claimant's reduced cervical motion was normal for claimant. In addition, Dr. Schilperoort's identification of postural aberrancies, deconditioning, depression or other psychological conditions as potential contributing factors is conclusory and speculative. More importantly, a causal contribution from any or all of these factors does not rule out a concurrent material contribution from the MVA. Finally, unlike the majority, I would not discount Dr. Tomski's opinion because he did not rebut the contrary rationale of the other medical experts. Such rebuttal is unnecessary where, as here, the contrary medical opinion is unexplained and poorly-reasoned on its face.

For these reasons, I would affirm the ALJ's conclusion that claimant has met her burden of establishing a compensable claim for her current left knee and cervical conditions. Because the majority finds to the contrary, I respectfully dissent.

July 26, 1999 Cite as 51 Van Natta 1324 (1999)

In the Matter of the Compensation of
LURA F. CARTER, Claimant
WCB Case No. 98-07983
ORDER DENYING RECONSIDERATION
Allison Tyler, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

The self-insured employer requests reconsideration of those portions of our July 9, 1999 order that: (1) denied the employer's motion to strike claimant's copy of the notice of hearing attached to her brief; (2) found that the employer's failure to appear at the hearing was unjustified and constituted a "waiver of appearance" under OAR 438-006-0071; (3) found that no postponement or continuance option was available to the employer; (4) denied the employer's request for remand; (5) affirmed the ALJ's order setting aside the employer's *de facto* denial of claimant's right ulnar nerve condition; and (6) affirmed the ALJ's order assessing a penalty for the employer's unreasonable delay in processing the claim.

After reviewing the employer's motion, we find that the employer essentially raises the same arguments that we addressed in our order and we have nothing further to add to our prior order. Consequently, the employer's request for reconsideration is denied and we adhere to our July 9, 1999 order. The parties' rights of appeal shall continue to run from the date of that order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROYCE A. REYNOLDS, Claimant
WCB Case No. 98-03732
ORDER ON REVIEW
Robert G. Dolton, 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) Michael V. Johnson's order that assessed a $3,800 attorney fee for claimant's counsel's services at hearing. On review, the issue is attorney fees.

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

Claimant requested a hearing challenging SAIF's denial of his neck condition. Following the hearing, the ALJ found that claimant had established the compensability of his neck condition and set aside SAIF's denial. The ALJ also assessed an attorney fee of $3,800 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 all of the factors set forth in the rule. SAIF also asserts that the ALJ's explanation for the $3,800 fee award is insufficient. But, 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999).

Here, the ALJ cited to the applicable rule and identified the factors to be considered in determining the fee. The ALJ particularly considered the time devoted to the case, the complexity of the issues involved, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated. The ALJ's explanation for the $3,800 attorney fee award is therefore consistent with the *Underwood* rationale. *See Leslie D. Custer*, 51 Van Natta 390 (1999); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).[1]

ORDER

The ALJ's order dated April 2, 1999 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 (1986).

In the Matter of the Compensation of
FRANSISCO TAFOLLA, Claimant
WCB Case No. 98-08470
ORDER ON REVIEW
Cummins, Goodman, et al, Claimant Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that affirmed an Order on Reconsideration that did not award any unscheduled permanent disability for a low back injury. In his request for review, claimant also requests that he be allowed to submit additional evidence. On review, the issues are remand and extent of unscheduled permanent disability. We decline to remand and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has not submitted an appellate brief in this matter. However, in his request for review, claimant requested that he be allowed to submit additional evidence and testimony. We treat claimant's request as a motion for remand for the submission of further evidence.

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*, 70 Or App 416 (1986).

Claimant's request for hearing concerned the extent of permanent disability that was determined by a July 7, 1998 Order on Reconsideration. Pursuant to ORS 656.283(7), the extent of an injured worker's permanent disability is determined as of the date of issuance of the reconsideration order. Therefore, "post-reconsideration" evidence concerning an injured worker's condition cannot be considered. In addition, ORS 656.283(7) prohibits the admission of any evidence that was not contained in the reconsideration record. *See Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996). Because the evidence claimant seeks to submit necessarily concerns his low back condition after the date of the reconsideration order, and because such evidence was not in the reconsideration record, it would not be admissible at hearing. Since the evidence would not be admissible, there is no compelling reason to remand this matter to the ALJ for further proceedings. Consequently, we decline to remand this matter to the ALJ.

Permanent Disability Benefits

We adopt the conclusions and reasoning concerning the extent of claimant's unscheduled permanent disability set forth in the ALJ's order.

ORDER

The ALJ's order dated February 23, 1999 is affirmed.

In the Matter of the Compensation of
DARIN K. THOMAS, Claimant
WCB Case No. 98-09355
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's L5-S1 herniated disc condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following change and supplementation. In the first paragraph on page 2, we change the first sentence to read: "Claimant and Crafton filled out an accident report for a back injury."

We agree with the ALJ's reasoning and conclusion that claimant's L5-S1 herniated disc condition is compensable. We write only to address the insurer's argument that the "major contributing cause" standard applies to this "combined/consequential condition" claim.

We find no medical evidence that supports the insurer's position that claimant's L5-S1 herniated disc condition should be analyzed as a consequential condition under ORS 656.005(7)(a)(A).

Moreover, the medical evidence does not persuasively establish that claimant's L5-S1 herniated disc condition should be analyzed as a combined condition under ORS 656.005(7)(a)(B). An MRI on July 22, 1998 indicated that claimant had mild degenerative disc disease at L5-S1 with associated mild to moderate left posterior lateral disc herniation. (Ex. 16). Even if we assume, without deciding, that the degenerative disc disease at L5-S1 preexisted claimant's September 17, 1997 injury, the medical evidence does not persuasively establish that any such degenerative changes "combined" with the work injury to cause or prolong claimant's disability or need for treatment. The insurer relies on the report from Drs. Zivin and Thompson to establish a combined condition. Drs. Zivin and Thompson commented that "[i]f a defined work injury can be proven, then an issue of combining of preexisting conditions plus injury or exposure arises * * *." (Ex. 21-11). Their comment that an "issue of combining" would "arise" if there was a defined injury suggests only the possibility that claimant's preexisting conditions combined with the work injury to cause or prolong disability or need for treatment. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981). We agree with the ALJ that the medical evidence is not persuasive that a preexisting condition combined with the September 1997 work injury. Therefore, claimant need only establish that his work injury was a material contributing cause of his disability and need for treatment. *See* ORS 656.005(7)(a); *Beverly Enterprises v. Michl*, 150 Or App 357 (1997).

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 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 March 22, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by the insurer.

In the Matter of Compensation of
LINDA J. WILLIAMS, Claimant
WCB Case No. 98-06508
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of her bilateral hand and arm conditions. On review, the issue is compensability.

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

We agree with the ALJ that Dr. Long's opinion on causation is not sufficient to establish compensability. In addition, in light of the contrary medical evidence, we are not persuaded by Dr. Long's opinion that claimant had cervical root and cervical cord compromise as a result of C5-6 and C6-7 disc lesions. (Ex. 33-2).

Claimant's previous treating physicians expressed concerns that claimant's symptoms were psychologically-based. In June 1995, Dr. Howieson reported that most of claimant's hand and arm symptoms were "psychophysiological" and he felt she would continue to manifest somatic complaints. (Ex. 1-2, -3). On July 2, 1998, Dr. Ash suspected that claimant's hand condition was "most likely going to be somatoform plus extensor tendinitis." (Ex. 6-2). He recommended a cervical MRI, which he found was negative. (Ex. 7A). On August 25, 1998, Dr. Ash noted that claimant's arm tremor appeared to be voluntary and he indicated that he had spoken to her about psychotherapy. (Ex. 11A). He recommended a brain MRI, which was negative. (Exs. 11A, 11B). Dr. Ash subsequently noted there was an anxiety component to claimant's symptoms. (Ex. 12).

Drs. Arbeene and Williams, who examined claimant on behalf of the insurer, found numerous examples of nonorganic behavior during their examination and they felt that functional overlay was a significant factor. (Ex. 10-5, -6). Drs. Dordevich, Morton, Labs and Wicher performed a multidisciplinary evaluation and concluded that claimant had chronic right upper extremity complaints without evidence of specific anatomical abnormality. (Ex. 26-13). They concluded that psychological factors played a role in claimant's symptoms. (Ex. 26-12). In light of the foregoing medical opinions, we do not find Dr. Long's diagnosis of C5-6 and C6-7 disc lesions persuasive.

ORDER

The ALJ's order dated April 13, 1999 is affirmed.

In the Matter of the Compensation of
MIHAI CONTRA, Claimant
WCB Case No. 98-02814
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denials 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.

When analyzing medical opinions, absent persuasive reasons to the contrary, we defer to the treating physician's opinion. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinion of claimant's treating surgeon, Dr. Franks. Dr. Franks based his opinion on an accurate history in that he understood that claimant's radicular symptoms did not begin until several weeks after the June 16, 1997 incident. (Ex. 47-26, 47-27). Dr. Franks also explained why he thought that the work injury was the major contributing cause of claimant's need for treatment and disability. (Exs. 44, 46, 47-28).

Thus, along with the reasons provided by the ALJ, we find that Dr. Franks' opinion was sufficient to carry claimant's burden of proof. ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 March 30, 1999 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
TED E. DAVIS, Claimant
WCB Case No. 98-08444
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated January 29, 1999 is affirmed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability of his low back injury claim. Thus, I dissent.

Claimant testified that, on Friday, July 17, 1998, while loading a truck, he felt lower back pain, as well as pain in his right hip and leg. (Tr. 5-6). When the pain did not abate, claimant sought treatment on Sunday, July 19. (*Id.* at 7-8). Dr. Brett performed surgery on July 20.

According to Dr. Brett, the July 17 work injury directly resulted in claimant's disc pathology and need for surgery. (Ex. 29-1). Consistent with claimant's history, Dr. Brett relied on a history that the incident caused immediate pain into the low back and right buttock. (*Id.*) Dr. Brett also explained that the incident was sufficient to cause "annular tearing and sequestration of disc material" and then the development of radicular symptoms. (*Id.*)

The majority agreed with the ALJ that Dr. Brett's opinion was not sufficient to carry claimant's burden of proof on the basis that he did not rely on an accurate history. In particular, the ALJ relied on the testimony of a co-worker that "there were no complaints or other indicia of pain on the day of injury that one would associate with a discogenic event." In sum, the ALJ found claimant did not exhibit enough pain behavior to support Dr. Brett's understanding that claimant sustained immediate pain into the low back and right buttock.

As we generally do, I would defer to Dr. Brett's opinion as the treating surgeon. *See Weiland v. SAIF*, 64 Or App 810 (1983). No one disputes claimant's testimony that he was performing heavy work by lifting and loading doors into a truck. Moreover, claimant clearly had a herniated disc that required immediate medical attention.

I disagree with the majority that the co-worker's testimony necessarily shows that claimant was not experiencing low back and right buttock pain at work. Claimant's testimony is supported by the emergency room chartnotes (Ex. 2-1), the Form 827 (Ex. 4), and the Form 801 (Ex. 11). Thus, claimant has been a consistent historian concerning the injury. Furthermore, there is no medical evidence that claimant's symptoms should have been visually apparent to his co-workers; in my opinion, the co-worker's testimony is not dispositive as to whether claimant was injured on July 17.

Consequently, because I disagree that Dr. Brett relied on an inaccurate history, I find no persuasive reasons not to defer to his opinion. Because Dr. Brett established that claimant's injury was the major contributing cause of his need for treatment and disability, claimant proved compensability. *See* ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
MICHAEL T. FOLEY, Claimant
WCB Case No. 98-06673
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's denial of his claim for a left scaphoid fracture with avascular necrosis and a left shoulder impingement condition. On review, the issue is compensability.

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

Claimant argues that the ALJ incorrectly applied the "major contributing cause" standard to the compensability of his left shoulder impingement condition and left scaphoid fracture with avascular necrosis.[1] However, even assuming that the material contributing cause standard applied, we find a failure of proof for the following reasons.

Because claimant had a prior forearm injury that required surgery, causation of the scaphoid fracture with avascular necrosis is a complex medical issue requiring medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967). Claimant's attending physician, Dr. Davis, indicated that he was unable to confirm the diagnosis of a scaphoid fracture, but apparently deferred to Dr. Lynch's diagnosis of the condition. Neither physician opined that the fracture was causally related to the compensable injury. Moreover, neither physician addressed whether the preexisting forearm injury and surgery played a role. Under such circumstances, even if the material contributing cause standard is applied, claimant has not established compensability of a scaphoid fracture with avascular necrosis.

With regard to the claimed left shoulder impingement condition, Dr. Davis opined that claimant did not have any additional compensable conditions other than the conditions already accepted by SAIF. Thus, we find insufficient evidence, even under the material contributing cause standard, that claimant had a compensable left shoulder impingement condition.

ORDER

The ALJ's order dated April 8, 1999 is affirmed.

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[1] No formal hearing was conducted and the case was decided on the written record. Although claimant contends on review that the material contributing cause standard applies, claimant argued in his written argument to the ALJ that the scaphoid and left shoulder conditions should be considered consequential conditions. Under ORS 656.005(7)(a)(A), the major contributing cause standard applies to determine the compensability of consequential conditions; thus, it would appear that claimant conceded to the ALJ that the major contributing cause standard applies to the compensability issue. For the reasons set forth in this order, however, we find that claimant failed to establish compensability under either the material or major standard. Thus, we need not address which standard is appropriate.

In the Matter of the Compensation of
M. CHERYL HANSON, aka M. C. CHURCH-HANSON, Claimant
WCB Case No. 98-08727
ORDER ON REVIEW
Philip H. Garrow & Janet Breyer, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that increased claimant's scheduled permanent disability from 1 percent (1.5 degrees) for each wrist (forearm), as awarded by an Order on Reconsideration, to 6 percent (9 degrees) for each wrist. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated March 26, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by SAIF.

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[1] In her statement of services, claimant's counsel requested double her usual hourly fee due to the contingent nature of the fee. SAIF objected to the requested fee (based on a multiplier of 2) as excessive. As SAIF notes, the Board has 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). This case is no exception. Instead of applying a multiplier of 2, we consider the risk that claimant's counsel may go uncompensated in conjunction with the other relevant factors of OAR 438-015-0010(4) in determining a reasonable attorney fee award. *See John M. Morley*, 50 Van Natta 1598 (1998).

In the Matter of the Compensation of
CHRIS W. LEISH, Claimant
WCB Case No. 98-06796
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Martha J. Brown's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) assessed a $3,300 attorney fee for claimant's counsel's services at hearing. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation on the attorney fee issue.

Claimant requested a hearing challenging SAIF's denial of his right shoulder condition. Following the hearing, the ALJ found that claimant had established a compensable occupational disease of the right shoulder under ORS 656.802(2)(a) and directed SAIF to accept and process the claim. The ALJ also assessed an attorney fee of $3,300 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 all of the factors set forth in the rule. SAIF also asserts that the ALJ's explanation for the $3,300 fee award is insufficient. But, 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 a brief description or citation to the rule-based factor or factors relied upon in determining the fee award. *See also SAIF v. Bacon*, 160 Or App 596 (1999).

Here, the ALJ cited to the applicable rule and identified the factors she considered in determining the fee. The ALJ explained that, in awarding the $3,300 fee, she 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); *compare Donna R. Grierson*, 51 Van Natta 679 (1999) (ALJ's reasoning insufficient to determine how he arrived at reasonable fee where order was devoid of any explanation of application of the rule-based factors).

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

ORDER

The ALJ's order dated March 24, 1999 is affirmed. For services on review, claimant's counsel is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
BETTY L. KNEELAND, Claimant
WCB Case No. 97-04934
ORDER ON REMAND
Callahan & Stevens, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. *Silverton Thriftway v. Kneeland*, 159 Or App 435 (1999). The court has reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that had set aside the insurer's partial denial of claimant's injury claim for right gluteal/sacroiliac strain (with possible piriformis syndrome), pain associated with the accepted lumbosacral strain/sprain, chronic pain syndrome, and depression. Concluding that our order did not address the issue of whether objective findings supported the compensability of the denied conditions under ORS 656.005(7), and did not explain why, if at all, the ALJ's opinion was sufficient with regard to that issue, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the factual background of the claim. On March 22, 1995, claimant injured her lower back while in the course of employment. The insurer accepted a claim for a disabling lumbosacral strain. Claimant was declared medically stationary on June 17,1996, after which the insurer closed the claim on July 15, 1996. Claimant received an award of unscheduled permanent partial disability. At claimant's request, the Department reconsidered the claim closure and, in its November 1996 Order on Reconsideration, reduced the previously awarded unscheduled award to zero.

Subsequently, in a February 1997 letter, claimant requested that the insurer accept the following: (1) Pain condition associated with accepted physical condition; (2) Right gluteal with piriformis syndrome; (3) Chronic pain syndrome; (4) Depression; and (5) Degenerative disc disease in the lumbar spine.

The insurer denied the claim, and claimant requested a hearing.

The ALJ upheld the denial of the claim as it pertained to the degenerative disc disease because claimant had withdrawn her claim with regard to that condition. The ALJ set aside the denial as it pertained to the remaining conditions. The ALJ accepted the opinions of Dr. Donovan and Dr. Morris that the March 22, 1995 injury was the major contributing cause of the denied conditions and discounted the opinions of examining physicians.

The insurer requested review and argued that the denied conditions were not compensable. One of the insurer's arguments was that the denied conditions were not supported by "objective findings" as required by ORS 656.005(7) and (19). We adopted and affirmed the ALJ's order.

The insurer then sought judicial review by the Court of Appeals, arguing that we found the denied conditions compensable without determining whether there were objective findings to support them as required by ORS 656.005(7) and (19). At oral argument, counsel for the insurer asserted that, because we failed to find that objective findings that are consistent with the applicable statutory standard existed, our order was inadequate for judicial review. The court agreed and remanded for reconsideration.

In accordance with the court's instructions, we now proceed with our analysis. 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 Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997). Meeting any one of the latter three requirements satisfies the statute. *Id.* at 2448.

In this case, we conclude that "objective findings" supported the compensability of the denied conditions. First, we discuss the diagnosed right gluteal/right sacroiliac strain (with possible piriformis syndrome).

Dr. Donovan noted on several occasions that claimant had reduced range of motion (Exs. 18-2, 19-4, 25-4). She also noted on two examinations that there was positive piriformis testing. (Exs. 18-2, 19-6). Range of motion is specifically listed as an "objective finding" in ORS 656.005(19), and, because Dr. Donovan noted positive piriformis testing on more than one occasion, the piriformis findings were "reproducible." Thus, we conclude that the denied right gluteal/right sacroiliac strain (with possible piriformis syndrome) condition was supported by "objective findings."

We acknowledge that, at times, some physicians (Drs. Miller and Peterson) have indicated that claimant's range of motion measurements were unreliable or invalid. (Exs. 30, 32-7). The attending physician, Dr. Donovan, however, has noted reduced range of motion without expressing concerns regarding the validity of her findings. (*e.g.* Ex. 18-2). Under such circumstances, we are persuaded that "objective findings" support the compensability of the gluteal/right sacroiliac strain condition.

We now turn to the other denied conditions. Dr. Morris, a psychologist, diagnosed a "pain condition associated with both medical and psychological factors," as well as "depression." (Ex. 24-5). These diagnoses were supported by behavioral observations, test results and interpretation. (Ex. 24-3, 4). We conclude that such findings (which were not contradicted) were verifiable, observable indications of injury or disease, and, thus, constitute "objective findings" in support of the compensability of these conditions.

Finally, as a result of the medical arbiter's examination, Dr. Peterson diagnosed a "chronic pain syndrome." (Ex. 32-7). The compensability of this condition was supported by objective findings consisting of tenderness over the right sciatic notch and right sacroiliac joint. *Id.*[1]

In summary, we find the compensability of the denied conditions was supported by "objective findings" as required under ORS 656.005(19). Therefore, we continue to conclude that the disputed conditions are compensable.

Claimant has finally prevailed after remand regarding the compensability of the denied conditions. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. Inasmuch as claimant has received a fee for services at hearing and on review, the only forum for which she has not received a fee is the Court of Appeals.

Therefore, after considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services before the Court of Appeals is $3,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief before the court), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, our March 31, 1998 order, which affirmed the ALJ's order dated November 5, 1997, is republished, as supplemented herein. For services rendered at the appellate court level, claimant's attorney is awarded a $3,000 attorney fee, payable by the insurer.

IT IS SO ORDERED.

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[1] Tenderness was previously noted over the right sacroiliac joint. (Exs. 18-2). Accordingly, we find that "tenderness" was reproducible and constitutes a valid objective finding. *See Joseph M. Stransky*, 51 Van Natta 143, 144 (1999); *Marilyn M. Keener*, 49 Van Natta 110, 112 (1997) (finding "tenderness" to be an objective finding).

In the Matter of the Compensation of
SALLY D. YATES, Claimant
WCB Case No. 98-02404
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside its denial of claimant's current low back/lumbar and right sacroiliac/right leg condition; and (2) found that the insurer's preclosure denials of accepted conditions that were neither combined nor consequential conditions were improper. On review, the issues are the propriety of the employer's denials and compensability of claimant's current condition. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph on page 2, we change the first sentence to read: "Claimant's cervical spine x-rays on December 7, 1992 showed a minor small central disc herniation at C3-4. (Ex. 2)." In the third paragraph on page 2, we change the fourth sentence to read: "A May 1995 lumbar spine CT showed no evidence of focal disk extrusion. (Ex. 29)." On page 3, we change the second full paragraph to read:

"On February 11, 1998, Drs. Waldram and Phipps examined claimant on behalf of the employer. (Ex. 86). They diagnosed a chronic low back strain, mild L4-5 degenerative arthritis and chronic cervical strain. (Ex. 86-3). They found that the major cause of claimant's current disability and need for treatment was her underlying problems. (Ex. 86-4)."

CONCLUSIONS OF LAW AND OPINION

Preclosure Denial

As a result of claimant's February 17, 1997 motor vehicle accident, the employer accepted cervical strain, thoracic strain, lumbar strain, left shoulder contusion, right thumb strain, cerebral contusion, left shoulder strain, left elbow contusion, cephalgia, right knee contusion, pelvic somatic dysfunction and bilateral thigh contusions. (Exs. 56, 63, 92). On March 16, 1998, the employer issued a partial denial of claimant's "current condition." (Ex. 90).

The ALJ found that claimant had a preexisting condition in the low/lumbar back and right SI joint with radiation. The ALJ found that the employer could properly issue preclosure denials for those accepted conditions that were "combined" conditions. On the other hand, the ALJ concluded that the employer's preclosure denials of claimant's accepted conditions that were not combined or consequential conditions was improper.

On review, the employer argues that its preclosure denials of the condition that did not preexist the injury was proper. We disagree.

Under ORS 656.262(7)(b), after a worker's claim has been accepted, the carrier "must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." In *Tracey A. Blamires*, 50 Van Natta 1793, *on recon* 50 Van Natta 2273 (1998), we construed the statute as providing that, whether or not the carrier has accepted a combined condition, the carrier may avail itself of the "preclosure" 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, claimant acknowledges that she has a preexisting condition in the low/lumbar back and right SI joint with radiation and she agrees that ORS 656.005(7)(a)(B) applies in determinining compensability of her current low back condition. We agree with claimant that the medical evidence establishes that the preexisting condition combined with the accepted conditions of lumbar strain and pelvic somatic dysfunction to cause or prolong her disability or need for treatment. Consequently, to the extent the employer's denial denied claimant's current low back and right SI joint condition, it was properly issued under ORS 656.262(7)(b).

On the other hand, we find no evidence that the remainder of claimant's accepted conditions, *i.e.*, cervical strain, thoracic strain, left shoulder contusion, right thumb strain, cerebral contusion, left shoulder strain, left elbow contusion, cephalgia, right knee contusion and bilateral thigh contusions, combined with any preexisting conditions. Consequently, ORS 656.262(7)(b) does not allow for a "preclosure" denial of those conditions and we agree with the ALJ that those portions of the employer's denial should be set aside as procedurally invalid.

Current Condition Denial

We adopt and affirm the portion of the ALJ's order that concluded that claimant has established compensability of her current low back/lumbar and right sacroiliac/right leg condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 8, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,750, payable by the employer.

July 26, 1999 Cite as 51 Van Natta 1337 (1999)

In the Matter of the Compensation of
CHARLOTTE J. KING, Claimant
WCB Case No. 98-02547
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of her bilateral carpal tunnel syndrome. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 3, we change the ninth paragraph to read: "On August 12, 1998, claimant began working at a job servicing ATM machines. (Tr. 139-40)." In the first full paragraph on page 5, we change the date in the fourth sentence to "October 20, 1997."

The insurer requests that the Board strike or disregard portions of claimant's reply brief raising arguments regarding the Americans With Disabilities Act and the Age Discrimination and Employment Act, as well as constitutional arguments. Because the record indicates claimant raised these arguments for the first time in her reply brief, we do not address them. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

ORDER

The ALJ's order dated March 16, 1999 is affirmed.

In the Matter of the Compensation of
CONNIE J. BARRS, Claimant
WCB Case No. 98-04851
ORDER ON REVIEW
Edward J. Harri, Claimant Attorney
Schwabe, et al, Defense Attorneys
Kryger, et al, Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside its denial of claimant's injury claim for a T11 fracture; (2) directed it to pay interim compensation for the period of May 8, 1998 to June 5, 1998; and (3) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. On review, the issues are compensability, entitlement to interim compensation, and penalties. We reverse.

FINDINGS OF FACT

Claimant, age 52 at the time of hearing, has worked as a cook and/or bartender for most of her adult life. She has a long history of low back injuries and symptoms. She first injured her back at age 15, but this incident did not require medical care. (Tr. 6). Then in 1970 or 1971, she reinjured her back when she was thrown against a door jam. She was scheduled for surgery, but the day before the scheduled surgery she was involved in a motor vehicle accident. She was placed in traction as a result of the motor vehicle accident and her back symptoms improved. (Tr. 6-7)

In 1976, while working as a bartender, claimant fell from a bar stool while dusting. She landed on her back and suffered a thoracic compression fracture. She did not work for approximately three and a half years after this incident. (Tr. 7, Exs. 2, 3).

In February 1985, while working as a cook, claimant slipped and fell on a greasy floor. She landed on her back. Following this incident, claimant experienced ongoing low back pain and left leg pain and numbness. She was diagnosed with a lumbar strain. In July 1985, claimant had a lumbar CT scan, which did not show any remarkable pathology. The radiologist's findings also included "an old compression fracture at T11." (Exs. 3, 4, 5, 6). Claimant was off work for about a year because of the February 1985 injury. (Tr. 9).

In January 1988, claimant sustained another slip and fall injury while working as a cook. She struck her head on a refrigerator and landed on the floor. (Tr. 9-10, 37). She was diagnosed with closed head injury and soft tissue injury. Claimant filed a claim for a low back strain and cervical strain that was eventually accepted by this former employer's carrier. Claimant was again off work for about a year following this injury. (Tr. 10).

Claimant continued to experience low back pain and right leg symptoms, which prompted another CT of the lumbar spine in April 1988. Radiologist Dr. Eyre concluded that the study was essentially negative. He also reported that claimant's "known" severe SI joint disease, and moderate grade compression fracture at T12 with T11-12 disc space disease were probably better candidates to account for claimant's symptoms. (Ex. 29)

By May 1988, claimant's treating doctors suspected that claimant's ongoing symptoms were due to rheumatoid spondylitis or sacroiliitis. (Exs. 38, 40). In July 1988, Dr. MacMillian diagnosed sacroiliitis. He also noted "evidence of an old injury of the vertebral bodies of T11 and T12." (Ex. 52). Similarly, in September 1988, Dr. Melgard, who examined claimant with regard to her back and right leg pain and pain between the shoulder blades, noted a history of previous compression fractures at "D12 and D11." (Ex. 60). In October 1988, a myleogram and post-myelogram CT scan was read by Dr. Mueller as showing an old compression fracture of T12, degenerative disc changes about T11-12 and to a lesser extent T12-L1. (Ex. 61). Dr. Tiley indicated that when he first saw claimant in 1982, her x-rays demonstrated an old compression fracture of T12. He noted that claimant's current studies showed the old compression fracture and degenerative disc disease. He suspected that claimant's symptoms were due to some sacroiliac inflammatory disease. (Ex. 62).

In November 1988, claimant was referred to Dr. May, who diagnosed ankylosing spondylitis and mild collagen vascular disease. Dr. May also reviewed claimant's past CT scans, which indicated that claimant had an old compression fracture at T12 and degenerative changes about the T11-T12 and T12-L1 disc spaces. (Exs. 63, 66, 68). In June 1989, claimant's January 1988 injury claim was resolved by a Disputed Claim Settlement. (Ex. 76).

In May 1991, claimant had a chest x-ray, with essentially normal findings. Dr. Anderson did note, however, some degenerative changes about the intervertebral disc lines of the thoracic spine. (Ex. 77).

In June 1993, claimant was struck in the low back by a door handle while working as a cook for another former employer. (Tr. 11). She received conservative treatment for her low back pain. An MRI scan of the lumbar spine identified no neural compression. Dr. Erba also noted a possible minimal wedge compression deformity of the T12 centrum. (Ex. 83). By late August 1993, Dr. Buza determined that claimant had returned to her pre-June 1993 injury status, and that she was medically stationary with regard to this injury. (Ex. 86). The June 1993 injury claim was closed in September 1993 with an award of temporary disability only. (Ex. 88).

Claimant continued to experience low back pain, but was not disabled from work. (Tr. 13-15). But, on February 26, 1998, while working as a cook for the employer in this case, she sustained another injury. She slipped and fell to the floor, landing on her right elbow and right side of her body. She experienced the immediate onset of pain and weakness on the right arm and burning sensations in her legs. (Tr. 18-19). Over the next few days, she also developed upper back and neck pain. (Tr. 20).

Claimant sought treatment from Dr. Donovan on March 2, 1998, who diagnosed cervical and thoracic strain injuries secondary to the fall at work and chronic back pain related to prior injuries. Among other findings, Dr. Donovan noted that claimant had some tenderness over the mid-thoracic area to palpation and fairly full thoracic rotation. Claimant reported that it felt good to stretch her neck and mid back. (Ex. 90).

Claimant continued to perform her regular job until her employment was terminated in mid-March 1998. (Tr. 22). Eleven days later, she began a new job with another employer. She worked for the new employer until May 8, 1998, when she was released from work by Dr. Daniels.

Meanwhile, on March 16, 1998, claimant returned to Dr. Donovan complaining of thoracic pain. Dr. Donovan ordered an x-ray of the thoracic and lumbar spine to rule out a compression fracture. (Ex. 93). Dr. Eyre read the x-ray as showing an old compression fracture at T12, unchanged since June 1993. Dr. Eyre also noted 20 percent compression of the anterior half of the body of T11, at the expense of smooth bordered end plate intrusions with slight buckling of the anterior cortical surface that was suspicious of a fresh injury. (Ex. 92).

On April 14, 1998, Dr. Donovan diagnosed a new T11 compression fracture secondary to claimant's February 1998 fall and chronic pain related to claimant's prior injuries. (Exs. 94, 95). In May 1998, claimant began treating with Dr. Daniels.

On May 21, 1998, claimant underwent an MRI of the lumbar spine. Dr. Erba reported that the lumbar spine was unchanged when compared to the June 1993 study. Dr. Erba also noted that barely visualized along the edges of the film were Schmorl's nodes involving the superior T12 end plate. (Ex. 107).

On June 2, 1998, claimant was examined by Dr. Bald at the employer's request. Dr. Bald found, among other things, some mild tenderness localized to the mid-thoracic area at T8 and moderate tenderness over the entire lumbar region, L4 to mid-sacrum. He concluded that claimant's 1993 and 1998 MRI scans showed the old compression fracture at T12, but he saw no evidence of any significant new injury. (Ex. 110).

In late June 1998, claimant was referred to Dr. Mayhall because of her persistent back and leg pain. Dr. Mayhall diagnosed thoracic, cervical and lumbosacral sprains and a new compression fracture at T11, based on the x-ray report. (Exs. 115, 117)

In September 1998, claimant began treating with Dr. Neuberg. Dr. Neuberg requested claimant's prior imaging studies to determine whether the thoracic compression fracture that had been recently diagnosed was actually preexisting. (Exs. 124, 125). On September 28, 1998, Dr. Burke, a radiologist, compared claimant's 1988 and 1998 films. She noted that the T11 vertebral body is only seen on the lateral view on 1988, and is not in the field of view in the AP film. Dr. Burke found a similar degree of anterior wedging of the T12 vertebral body since 1988 and interval development of anterior and lateral osteophytes at T11 and 12 that appear to contribute to the appearance of the cortical buckling at T11. Dr. Burke did not concur that there was an acute compression fracture at T11. (Ex. 126).

On November 23, 1998, claimant underwent a MRI of the thoracic spine. Dr. Green read the study as showing a moderate old compression fracture of T11, not acute, otherwise negative. (Ex. 127).

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on the opinions of Drs. Donovan and Mayhall, the ALJ determined that claimant established the compensability of a T11 fracture. On review, the employer contends that claimant has not carried her burden of proof. We agree with the employer.

The dispute in this case centers on whether claimant sustained a new compression fracture of T11 as a result of her February 26, 1998 fall at work. Claimant has the burden of proving the compensability of her claim by a preponderance of the evidence. ORS 656.266. *Hutcheson v. Weyerhaeuser*, 288 Or 51 (1979). Here, because the diagnosis and causation of the claimed T11 fracture involves issues best resolved by expert analysis rather than expert external observations, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979).

Dr. Donovan, who treated claimant during March, April and May 1998, opined that claimant's February 1998 fall caused a T11 compression fracture. Dr. Donovan indicated that her opinion was based on the x-ray, although it is not clear from the record whether Dr. Donovan reviewed the March 1998 film herself or whether she relied exclusively upon Dr. Eyre's report.[1] But, to the extent Dr. Donovan's opinion is based upon Dr. Eyre's report, we note that Dr. Eyre did not find clear evidence of a new injury at T11. Rather, Dr. Eyre read the March 1998 x-ray as being "suspicious" for a new injury at T11. (Ex. 92). We consider a "suspicion" to be similar to a "possibility," rather than a medical probability. As such, the comment is not persuasive evidence of the existence of a new T11 injury. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981). We also find Dr. Donovan's "check-the-box" opinion unpersuasive because it is lacking in explanation and analysis. *See, e.g., Beverly M. Brown*, 46 Van Natta 2455 (1994) (Board gives little, if any, weight to conclusory opinions such as unexplained "check-the-box" reports, which lack persuasive foundation); *Marta I. Gomez*, 46 Van Natta 1654 (1994).

Dr. Mayhall, who personally reviewed claimant's December 1998 MRI scan, opined that "there might be" some change in the signal at the superior end of plate T11 and the inferior plate of T10. He noted that the height of the T11 vertebral body was poorly seen and he could not measure it. He nevertheless interpreted the study to show a mild loss of height at T11, which he believed was consistent with a compression fracture at T11 (in addition to the preexisting fracture at T12). He then concluded that claimant "appeared to have" a new compression fracture subsequent to the T12 compression fracture. (Ex. 129).

After considering Dr. Mayhall's reading of claimant's 1998 MRI studies in light of the other expert medical evidence in the record, we find his opinion insufficient to sustain claimant's burden. First, his opinion is couched in terms of possibility (*i.e.*, "there might be" some change and claimant "appeared to have" suffered a new injury) rather than medical probability, which is not legally sufficient nor persuasive. *See Gormley*, 52 Or App at 1060. Second, although Dr. Mayhall interpreted the film as showing a mild loss of height at T11, which he believed was "consistent with" a compression fracture, he admitted that the height was poorly seen and could not be measured. Third, in rendering his

[1] It is also not evident from the record whether Dr. Donovan reviewed any films or radiographic studies that predated claimant's February 1998 fall.

opinion, Dr. Mayhall did not address claimant's well-documented history of preexisting degenerative changes at T11-12 or rule out the possibility that the MRI findings were also consistent with a degenerative condition.[2]

Furthermore, despite Dr. Mayhall's suggestion that his assessment of claimant's December 1998 MRI was essentially consistent with Dr. Green's evaluation of the film, we find to the contrary. Dr. Green interpreted the thoracic spine MRI as showing a moderate compression fracture of T11 vertebral body, not acute. He reported that the absence of marrow signal alterations indicated that the fracture was "almost certainly old." (Ex. 127). Dr. Green did not identify two thoracic compression fractures, one much older than the other (as did Dr. Mayhall), nor did his report mention a T12 compression. Under these circumstances, we are unwilling to interpret Dr. Green's report as consistent with a relatively "new" compression fracture (*i.e.*, less than a year old) in addition to, and subsequent to, the well-documented "old" compression fracture.[3]

Dr. Bald examined claimant about three months after her February 1998 fall. Unlike Drs. Donovan and Mayhall, Dr. Bald opined that claimant did not sustain a new T11 fracture injury. He explained that the historical picture of the onset of claimant's symptomatology, the findings noted by Dr. Donovan in March 1998 and the radiological studies did not support such a diagnosis. Dr. Bald indicated that, had claimant sustained a compression fracture of T11 as a result of this injury, she would likely have experienced considerable acute and severe pain localized to her lower thoracic and lumbar spine, as well as some difficulty breathing or shortness of breath. But, rather than severe symptoms in the region of T11, claimant's complaints on her initial visit to Dr. Donovan were primarily related to her neck and upper back.[4] Dr. Bald also noted that, at the time of his examination of claimant, she had no pain complaints referable to her lower thoracic spine. Neither Dr. Donovan nor Dr. Mayhall offered opinions rebutting Dr. Bald's assessment of claimant's clinical presentation.

Consequently, on this record, we conclude that claimant has not established by a preponderance of the evidence that she suffered a new T11 fracture as a result of her February 1998 fall.

Interim Compensation

The ALJ determined that claimant was entitled to interim compensation for the period from May 8, 1998, when she was released from work by Dr. Daniels, to the date of the denial, June 5, 1998. On review, the employer asserts that it had no notice that claimant had been taken off work until May 26, 1998, at the earliest, and that claimant was not entitled to interim compensation because the denial issued within two weeks of that date. We agree, for the reasons set forth below.

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[2] In other words, Dr. Mayhall did not address Dr. Burke's conclusion that there was no evidence of an acute compression fracture at T11, and that the appearance of buckling of the cortical surface described may be attributed to a superposition of lateral osteophytes. Unlike Dr. Mayhall, who did not review any pre-1998 studies, Dr. Burke's opinion was based on a comparison of claimant's May 1988 and March 1998 x-rays. (*See* Ex. 126).

[3] We recognize that, taken at face value, the medical evidence in this case is essentially irreconcilable. For example, although a July 1985 CT scan identified an old compression fracture of T11 (Ex. 6), an October 1988 myleogram and post-myleogram CT was interpreted as showing old compression of T12 with degenerative changes about T11-12. (Ex. 61). And, in between these two studies, both Dr. MacMillian and Dr. Melgard found evidence of injury of the T11 *and* T12 vertebral bodies. (Exs. 52, 60). In 1993, Dr. Erba noted a possible compression deformity of T12, but did not address the status of T11 (or indicate whether this vertebrae was in the field of view in the study). (Ex. 83). Then, in 1998, claimant was variously diagnosed with an old compression fracture of T12 and possible new fracture of T11 (Ex. 92), an old compression fracture of T12 with no new acute injury of T11 (Ex. 126) and a moderate old fracture of T11, not acute, with no mention of T12. (Ex. 127). Although Drs. Mayhall and Donovan have opined that claimant has a new fracture at T11 attributable to the February 1998 incident, neither has adequately explained this conclusion in light of the varying diagnoses and other interpretations of claimant's condition. Because we are not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge, *see SAIF v. Calder*, 157 Or App 224 (1998), we are not in a position to determine whether certain studies were misread in the absence of expert medical opinion on the issue. We are also not permitted to substitute our own opinion for the medical evidence in the record.

[4] Indeed, although claimant complained of tenderness of the mid thoracic area on her March 2, 1998 visit to Dr. Donovan, Dr. Donovan noted that claimant had fairly full thoracic rotation that "feels good by [claimant's] report to stretch." (Ex. 90-2).

"Interim compensation," 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)). Interim compensation is due and payable beginning 14 days after the date upon the employer receives notice or knowledge of the claim *and* verification from the attending physician as to the worker's injury-related inability to work. ORS 656.262(4)(a)[5]; *See Marvin J. Gregory*, 49 Van Natta 1253 (1997); *Stephen M. Snyder*, 47 Van Natta 1956 (1995).

Here, claimant was working for another employer when she was released from work by Dr. Daniels on May 8, 1998.[6] (Ex.102). The record establishes, however, that the claims processor did not receive medical verification that claimant was off work until May 26, 1998, when it received the Change of Attending Physician form (the 829 form, signed by Dr. Daniels on May 13, 1998), indicating that claimant was unable to work due to a compression fracture. (Ex. 104). Therefore, under ORS 656.262(4)(a), temporary disability would be due and payable 14 days from May 26, 1998, the date the employer had notice of the claim *and* verification of claimant's inability to work. But because the employer denied the claim on June 5, 1998, less than 14 days after it received the medical verification of claimant's inability to work, there was no duty to pay interim compensation. *See Robert E. Vanwormer*, 46 Van Natta 328 (1994) (the claimant was not entitled to interim compensation where the employer denied the claim two days after it received notification that the claimant was off work, ostensibly for reasons related to the claimed work injury).

Finally, because we have found that claimant is not entitled to interim compensation for the period of May 8, 1998 to June 5, 1998, we reverse that portion of the ALJ's order that assessed a penalty arising out of the employer's alleged unreasonable refusal to pay such compensation.

ORDER

The ALJ's order dated February 24, 1999 is reversed in part and affirmed in part. That part of the order that set aside the employer's denial of the compression fracture of T11 is reversed, and this aspect of the denial is reinstated and upheld. Those parts of the order that directed the employer to pay interim compensation and assessed a penalty related to the interim compensation are also reversed. The remainder of the order is affirmed.

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[5] This section provides, in pertinent 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."

[6] After her February 1998 fall, claimant continued working for the employer until mid-March 1998. She started a new job eleven days later, and continued in that position until she was released from work on May 8, 1998 by her new attending physician, Dr. Daniels.

In the Matter of the Compensation of
JAMES M. EVANS, Claimant
Own Motion No. 99-0152M
OWN MOTION ORDER OF ABATEMENT
Martin L. Alvey, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our June 28, 1999 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The 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
VICTOR J. CERVANTES, Claimant
WCB Case Nos. 98-06842 & 98-01857
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Barrett Business Services (Barrett) requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) set aside its compensability and responsibility denials of claimant's left lateral and medial epicondylitis and right lateral epicondylitis conditions; (2) upheld the SAIF Corporation's responsibility denial of the same conditions; and (3) awarded an assessed attorney fee of $5,000. In its reply brief, Barrett submits an additional medical report from Dr. Neitling and requests remand for additional proceedings. SAIF objects to the motion to remand and moves to strike the additional report from Barrett's brief.[1] On review, the issues are remand, compensability, responsibility and attorney fees. We deny Barrett's motion to remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change and supplementation. In the first paragraph on page 2, we delete the third sentence and replace it with the following:

> "On July 14, 1994, claimant injured his left elbow while working for an employer in California. (Ex. .1). He was diagnosed with a left elbow contusion and he was released to full duty on July 18, 1994. (Exs. 1, 2, 5, 6)."

In the first sentence of the fourth full paragraph on page 3, we change the last portion of the sentence from "left medical epicondylitis" to "left medial epicondylitis."

CONCLUSIONS OF LAW AND OPINION

Remand

In its reply brief, Barrett submits a June 7, 1999 report from Dr. Neitling and requests that we include this exhibit in the record or remand for additional proceedings. According to Barrett, Dr. Neitling has corrected a typographical error in his February 4, 1998 chart note (Ex. 58), which is a "significant change and could change opinions as rendered regarding the issues of compensability and responsibility." (Barrett's reply br. at 2).

SAIF objects to Barrett's request for remand, arguing that Barrett did not exercise due diligence by attempting to obtain and submit the letter from Dr. Neitling previously. SAIF also contends that Barrett has failed to demonstrate a compelling reason for a remand.

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).

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[1] Barrett's reply brief is based, in part, on a document that was not admitted into evidence. Our review is limited to the record developed before the ALJ. *See* ORS 656.295(5). To the extent that Barrett's brief discusses a medical opinion not in the record, that document is not admitted but has been considered solely for the purposes of the remand issue. Therefore, we deny SAIF's motion to strike.

Dr. Neitling's June 7, 1999 report was not "available" at the time of the November 12, 1998 hearing or at the time the record closed on January 28, 1999. His June 7, 1999 letter commented on an April 21, 1999 report from Dr. Radecki (which was also generated after the hearing). Dr. Neitling commented that his "listed diagnoses remain the same and you have our medical records reflecting my opinions in this respect." Dr. Neitling had previously recommended surgery for claimant's elbows (Exs. 60, 61), and continued to do so on June 7, 1999. In addition, Dr. Neitling pointed out a typographical error in his February 4, 1998 chart note that changed a sentence in the "Physical Examination" section to read: "Resisted pronation brings on medial elbow symptoms bilaterally." (Underline in original). That portion of the February 4, 1998 chart note referred to "lateral" elbow symptoms rather than "medial" elbow symptoms.

Barrett has not established that the substance of the matters contained in the additional report from Dr. Neitling was unobtainable at the time of hearing with the exercise of due diligence. Furthermore, we are not persuaded that the proffered evidence would likely affect the outcome of the case. In the June 7, 1999 report, Dr. Neitling indicated that he adhered to his previous diagnoses and he again recommended surgery. We do not agree with Barrett's assertion that Dr. Neitling's typographical correction to the February 4, 1998 report is a "significant change," particularly since Dr. Neitling commented that his "listed diagnoses remain the same." In any event, even if we consider the document submitted by Barrett, we would still agree with the ALJ that claimant has established compensability of his left lateral and medial epicondylitis and right lateral epicondylitis conditions for which Barrett is responsible. Therefore, we conclude that the record was not improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ and, therefore, we decline to remand the case to the ALJ for additional proceedings.

Compensability

We adopt and affirm the ALJ's reasoning and conclusion that claimant's left lateral and medial epicondylitis and right lateral epicondylitis conditions are compensable. We write to address Barrett's argument that claimant has made inconsistent statements concerning his elbow symptoms and that Dr. Neitling's final report on causation (Ex. 91) showed that he has an inaccurate understanding of claimant's history.

The ALJ found that, despite some inconsistencies between claimant's statements regarding the onset of his symptoms and contemporaneous medical reports, those discrepancies did not significantly detract from claimant's credibility or from the medical opinions.

When the issue of credibility concerns the substance of a witness' testimony, however, 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, we agree with the ALJ's analysis and conclusions. To the extent claimant's statements conflict with the medical record regarding the onset of his symptoms, we find that the contemporaneous medical records are more reliable.

Barrett argues that Dr. Neitling's opinion is not persuasive because he was unaware of claimant's 1994 left elbow injury. We disagree.

The record indicates that claimant injured his left elbow while working for an employer in California on July 14, 1994. (Ex. 1). He was diagnosed with a left elbow contusion and he was released to full duty on July 18, 1994. (Exs. 1, 2, 5, 6). Claimant testified that he had a bruise from that injury that resolved and he said his current elbow condition is "completely different." (Tr. 24).

The medical reports indicate that Barrett had apparently asked Dr. Neitling about claimant's previous elbow injury in California and Dr. Neitling responded:

> "In our conversation, you mentioned that he may have filed a claim for elbow injury in California. This was in the distant past. Should you obtain those medical records, I would like to review them. *Basically, if he had an elbow injury with complete resolution of symptoms, the history of that elbow problem would probably not relate to his present elbow problem.* However, if he continued to have symptoms after that reported elbow injury, this is a significant bit of history that would be of importance in determining the exact etiology of his problems." (Ex. 75-1, -2; emphasis supplied).

The record indicates that claimant's 1994 elbow injury resolved and he was released to full duty 4 days after the injury. Under those circumstances, Dr. Neitling's opinion was that the 1994 injury was probably not related to the current elbow condition.

Barrett also argues that Dr. Neitling's history of claimant's symptoms is inaccurate because he is unaware that claimant had previously reported that his symptoms began months before his work at P & L (the company where Barrett assigned claimant to work). Barrett refers to claimant's January 14, 1998 "801" form, in which claimant indicated that his bilateral arm and hand condition had started one to two months before his employment with P & L. (Ex. 50).

As we discussed earlier, to the extent claimant's statements conflict with the medical record regarding the onset of symptoms, we find that the contemporaneous medical records are more reliable. Dr. Neitling said that he initially based his opinion on causation on the history from claimant, but he subsequently changed his opinion after reviewing additional medical records that were not previously available to him. (Ex. 91).

Finally, we acknowledge that claimant misrepresented his elbow problems in his employment application for Barrett. (Ex. 29). Nevertheless, even if a claimant lacks credibility with regard to certain matters, he can still meet his burden of proof where, as in this case, the remainder of the record supports his claim. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642 (1984), *rev den* 298 Or 597 (1985). We agree with the ALJ that claimant has established compensability of his left lateral and medial epicondylitis and right lateral epicondylitis conditions.

Responsibility

We adopt and affirm the ALJ's reasoning and conclusion that Barrett is responsible for claimant's left lateral and medial epicondylitis and right lateral epicondylitis.

Attorney Fees

Barrett contends that the ALJ's $5,000 attorney fee award is "extraordinarily high" and it asserts that the attorney fee should be reduced to about $3,000. Claimant argues that the ALJ's attorney fee award is reasonable and appropriate.

To begin, we note that the ALJ did not award an attorney fee under ORS 656.308(2)(d) for services concerning the responsibility issue. We must consider claimant's attorney fee for services at hearing with regard to compensability and responsibility. We determine the amount of claimant's counsel's attorney fee for services at the hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in this case were compensability and responsibility of claimant's left lateral and medial epicondylitis and right lateral epicondylitis conditions. Ninety-three exhibits were received into evidence, at least two of which were submitted by claimant's counsel. There were no depositions. The hearing lasted one hour and 45 minutes. Claimant testified on his own behalf.

Claimant's attorneys submitted a statement of services at hearing, requesting an attorney fee of $5,550 and indicating they had devoted approximately 16.5 hours to this case. Claimant's attorneys did not distinguish between services devoted to compensability as opposed to responsibility. We find no evidence in the record that claimant requested an extraordinary attorney fee at hearing. SAIF objected to claimant's counsel's statement of services on several grounds, contending that the fee request was excessive.

We agree with the ALJ that the compensability issue in this case was of average complexity. Because claimant's left lateral and medial epicondylitis and right lateral epicondylitis conditions have been found compensable, he is entitled to workers' compensation benefits, and the value of the interest

involved and the benefit secured for claimant are significant. The value of the claim may potentially include surgery and permanent disability benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Based on Barrett's compensability defense to the claim, there was a risk that claimant's counsel might go uncompensated for services rendered.

Based on our consideration of the factors in OAR 438-015-0010(4), particularly the aforementioned factors of value, benefit and risk, we conclude that $5,000 is a reasonable attorney fee for claimant's counsel's services at hearing. Because this case did not present extraordinary circumstances, $1,000 of this $5,000 attorney fee award is apportioned to claimant's counsel for active and meaningful participation at the hearings level in finally prevailing over Barrett's responsibility denial. ORS 656.308(2)(d); *see Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155 (1997).

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review regarding the compensability issue is $1,000, payable by Barrett. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's counsel is not entitled to a fee for services related to the responsibility and attorney fee issues. *See Foster-Wheeler Constructors v. Smith*, 151 Or App at 155; *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated February 27, 1999 is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded a $1,000 attorney fee, payable by Barrett.

July 27, 1999 Cite as 51 Van Natta 1346 (1999)

In the Matter of the Compensation of
MELVIN J. LUX, Claimant
Own Motion No. 99-0243M
OWN MOTION ORDER ON RECONSIDERATION
Schneider, et al, Claimant Attorneys

Claimant seeks Board authorization of an approved fee for his attorney's services culminating in our July 22, 1999 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,500, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0080.

Accordingly, our July 22, 1999 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our July 22, 1999 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EARL W. DAVIS, Claimant
WCB Case No. 98-05833
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that increased claimant's scheduled permanent disability for loss of use or function of his left leg from 15 percent (22.5 degrees), as awarded by an Order on Reconsideration, to 63 percent (94.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

The ALJ affirmed a Determination Order's award of 63 percent scheduled permanent disability for vascular impairment in claimant's left leg that an Order on Reconsideration had reduced to 15 percent. In doing so, the ALJ found the impairment rating of Dr. Davies, claimant's attending physician, more persuasive than that of the medical arbiter, Dr. Pitman. Dr. Davies had rated claimant's impairment as Class IV under OAR 436-035-0230(7)(d), whereas Dr. Pitman had rated claimant as Class II under subsection 7(b) of that rule.

In determining claimant's impairment, the ALJ rejected the insurer's argument that he could not consider claimant's written submissions to the Department made during the reconsideration process. In those submissions (which were contained in the "reconsideration record"), claimant, then unrepresented, described his symptoms, the affect of those symptoms on his work activities and the nature of Dr. Pitman's examination. (Exs. 16, 19). In particular, claimant alleged that Dr. Pitman's examination lasted only 7-10 minutes, that Dr. Pitman did not have his medical records, and that Dr. Pitman did not adequately evaluate his condition. (Ex. 19).

On review, the insurer contends that the ALJ's rejection of Dr. Pitman's report was an error insofar as he relied on claimant's unsworn statements regarding his physical condition and Dr. Pitman's examination. Citing OAR 436-030-0115, the insurer asserts that, while a claimant has a right to submit a sworn statement to the Department, there is no provision for unsworn testimony.[1] We disagree.

OAR 436-030-0115(3) allows for the submisson of "factual information" that includes, but is not limited to, sworn affidavits and "written statements." Claimant's letters qualify for incorporation into the reconsideration record under those standards. Moreover, we are not persuaded by the insurer's contention that allowing unsworn, written statements from injured workers will undermine "substantial justice." *See* ORS 656.283(7).

Citing *Adam Delfel*, 50 Van Natta 1041 (1998), the insurer argues that claimant's comments regarding the quality of the arbiter's examination are prohibited impeachment of the medical arbiter's report. In *Delfel*, we held that, in evaluating a claimant's permanent disability under the Director's disability standards, to the extent OAR 436-035-0007(12) and (13) could be interpreted as allowing consideration of impairment evidence from an examining physician whose opinion had not been ratified by an attending physician or medical arbiter, those rules were inconsistent with ORS 656.268(7) and ORS 656.245(2)(b)(B). Citing ORS 656.245(2)(b)(B), 656.268(7), *Tekronix, Inc. v. Watson*,132 Or App 483 (1995), and *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994), we concluded that only the attending physician at the time of claim closure, the medical arbiter, or other physicians with whom the attending physician concurs may make findings concerning a worker's impairment. 50 Van Natta at 1043.

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[1] OAR 436-030-0115 provides in subsection (3) that:

"All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record pursuant to ORS 656.268 (6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments of the opposing party, *written statements* and sworn affidavits from the parties." (emphasis supplied)

We further noted that the *Koitzsch* court had determined that the legislature intended to eliminate Board reliance on independent medical examinations as a basis for its evaluation of a worker's disability and had concluded that reports from examining physicians are not admissible for the purpose of impeaching a medical arbiter's opinion. Applying that rationale, we held that findings of an examining physician could not be used to "impeach" the opinion of the medical arbiter. *Id.*

We do not find *Delfel* controlling. Claimant is not an examining physician, nor do we believe that the legislature's intention of reducing reliance on independent medical examinations would be furthered by excluding written statements (which are contained in the "reconsideration record") of an injured worker regarding the nature of the arbiter's examination. In addition, we find this case similar to *Libbett v. Roseburg Forest Products*, 130 Or App 50 (1994).

There, the Court of Appeals held that *Koitzsch* does not preclude our use of non-medical evidence (in that case surveillance tapes) in the evaluation of the medical evidence or of a claimant's disability. *Id.* at 52. Claimant's statements in this case are not medical evidence. As such, in accordance with the *Libbett* rationale, they may be used in the evaluation of the medical evidence or claimant's disability. Therefore, because those statements are contained in the "reconsideration record," they are evidence that the ALJ could properly consider in his evaluation of the persuasiveness of the medical arbiter report.

The insurer also cites *Janice M. Davison*, 51 Van Natta 341 (1999) as support for its argument. There, we held that an *unsigned* affidavit contained in the reconsideration record was entitled no probative weight. *Id.* at 344. Unlike *Davison*, however, claimant's "reconsideration record" statements in this case were signed and expressly permitted under the applicable administrative rule. Therefore, we find *Davison* distinguishable.

Alternatively, even if we did not consider claimant's written statements, we would still find Dr. Pitman's report unpersuasive. In evaluating a worker's permanent impairment, we do not automatically rely on a medical arbiter's opinion 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).

As the ALJ noted, the limited nature of the arbiter's examination is apparent from the arbiter's report itself. The history contained in the report is cursory and Dr. Pitman relates claimant's symptoms to a chronic hamstring tear, a condition that no other physician diagnosed. Dr. Pitman's report of his physical examination is only 5 sentences long, only 3 of which pertained to the actual examination of claimant. (Ex. 22-2). We agree with the ALJ that Dr. Pitman's assessment of claimant's left leg impairment is not well-reasoned.[2] Thus, we do not find it persuasive.

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 $675, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 6, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $675, to be paid by the insurer.

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[2] In contrast, we find the medical opinion of Dr. Davies, based on his long-term familiarity with claimant's left leg condition, more persuasive than Dr. Pitman's. (Ex. 12).

In the Matter of the Compensation of
HERBERT L. LOCKETT, Claimant
WCB Case No. 98-07905
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes, Biehl, and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Otto's order reversing an Order on Reconsideration that found that his claim had been prematurely closed. On review, the issue is premature claim closure. We reverse and reinstate the Order on Reconsideration's finding that the claim had been prematurely closed.

FINDINGS OF FACT

On December 16, 1996, claimant, a recycling truck driver, was assaulted and robbed while in the course of his employment. While leaving his truck to get help, claimant fell on his right shoulder and knee. Claimant sought treatment from Dr. Brenneke for a right knee contusion and right shoulder impingement. Claimant also received treatment for a mental disorder, post traumatic stress disorder (PTSD).

Dr. Brenneke recommended arthroscopic right shoulder surgery in September 1997 to relieve suspected impingement. (Ex. 49). On February 25, 1998, the insurer accepted right shoulder strain, right knee contusion, and the PTSD condition.

On April 28, 1998, Dr. Brenneke withdrew as attending physician when claimant canceled surgery scheduled for April 30, 1998. (Ex. 78). On May 9, 1998, Dr. Brenneke indicated that claimant was released for modified work based on his lack of pursuit of curative treatment. (Ex. 80).

Claimant began treating with Dr. Craft on June 2, 1998. Dr. Craft removed claimant from work on June 15, 1998. (Ex. 84). On June 24, 1998, an examining physician, Dr. Laycoe, who evaluated claimant's physical condition in conjunction with an evaluation of claimant's mental condition by a psychiatrist (Dr. Howell), opined that claimant's right shoulder condition was medically stationary. (Ex. 86-3). Dr. Craft signed a form 829 (change of attending physician) on July 10, 1998. (Ex. 86A).

The insurer issued a Notice of Closure on July 15, 1998, finding that the claim qualified for closure on June 24, 1998, the date of the Laycoe/Howell examination. (Ex. 88). Although Dr. Craft had not concurred with the June 24, 1998 Lycoe/Howell report, the closure notice stated that the Laycoe/Howell evaluation constituted the closing examination.

Although no longer claimant's attending physician, Dr. Brenneke was asked for his concurrence with the Laycoe/Howell report. Dr. Brenneke signified his concurrence on July 17, 1998. (Ex. 89). Dr. Craft, however, again stated on July 17, 1998 that claimant was unable to work. (Ex. 90).

On August 6, 1998, claimant requested reconsideration, enclosing a release from Dr. Craft. (Ex. 91). Claimant asked for immediate rescission of the Notice of Closure, noting that the insurer had failed to obtain the attending physician's concurrence with the June 24, 1998 Laycoe/Howell examination. (Ex. 91).

On September 30, 1998, an Order on Reconsideration issued, rescinding the July 15, 1998 closure notice, finding that claimant's accepted conditions were not medically stationary when the claim was closed. (Ex. 94). The insurer requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ reversed the Order on Reconsideration and reinstated the July 15, 1998 Notice of Closure. In so doing, the ALJ determined that claimant's accepted physical and mental conditions were medically stationary at the time of claim closure. The ALJ also rejected claimant's contention, based on *Estella M. Rogan*, 50 Van Natta 205 (1998), that the closure was invalid because he had not been released for work prior to claim closure. The ALJ concluded that *Rogan* was not on point and, moreover, that claimant did not raise the propriety of the claim closure as an issue during the reconsideration process. *See* ORS 656.283(7) ("issues that were not raised by a party to the reconsideration may not be raised at hearing.").

On review, claimant contends that his right shoulder condition was not medically stationary at the time of claim closure. Moreover, claimant asserts that, because claimant's attending physician at closure, Dr. Craft, had not released him for work, the Notice of Closure was invalidly issued under ORS 656.268(4)(a).

For the following reasons, we conclude that the Notice of Closure improperly closed the claim in the absence of a release for work from Dr. Craft. Because of this procedural defect in the Notice of Closure, we need not address the issue of whether claimant's right shoulder condition was, in fact, medically stationary when the claim was closed.

In *Rogan*, we explained that ORS 656.268(4)(a) sets forth two prerequisites for a carrier's claim closure. The claim may be closed when: (1) the worker's condition has become medically stationary *and* the worker has returned or been released to work; or (2) the accepted injury is no longer the major contributing cause of the worker's combined or consequential condition. 50 Van Natta at 206. Although we held in *Rogan* that the Department is not authorized to set aside a carrier's closure notice as premature on the basis that the insurer did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4), it was undisputed in that case that the claimant's treating physician had declared the accepted conditions medically stationary and released the worker for regular work prior to the issuance of the Notice of Closure. Thus, the statutory conditions precedent to issuance of the closure notice had been satisfied. *Id.* at 207.

In this case, Dr. Craft, claimant's attending physician at claim closure, had not released claimant for regular or modified work prior to the claim closure. Thus, one of the statutory precedents to claim closure was not satisfied prior to claim closure. For this reason, we agree with claimant that the Notice of Closure prematurely closed the claim.

The ALJ determined, however, that claimant had not raised the procedural propriety of the claim closure during the reconsideration process and, therefore, that he could not address the issue. We disagree with the ALJ's conclusion. Claimant raised the general issue of premature claim closure during the reconsideration proceedings. (Exs. 91, 94-1). Moreover, in his request for reconsideration, claimant enclosed a copy of Dr. Craft's release from work. (Ex. 91). Under these circumstances, we find that claimant sufficiently raised the issue of the procedural propriety of the closure. Therefore, we conclude that this issue was properly before the ALJ.[1]

In conclusion, we find that the July 15, 1998 closure notice was prematurely issued. Therefore, we reverse the ALJ's decision upholding the claim closure.

Claimant's attorney is entitled to an out-of-compensation fee for his services at hearing and on review. ORS 656.386(2). Claimant's counsel is awarded an out-of-compensation fee equal to 25 percent of increased compensation created by this order, not to exceed $3,800, to be paid by the insurer directly to claimant's counsel. OAR 438-015-0055(1).

ORDER

The ALJ's order dated February 9, 1999, as reconsidered on March 24, 1999 is reversed. The September 30, 1998 Order on Reconsideration's finding that the claim was prematurely closed is reinstated and affirmed. The claim is remanded to the insurer for further processing in accordance with law. Claimant's counsel is awarded an out-of-compensation fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, to be paid by the insurer directly to claimant's counsel.

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[1] We also disagree with the ALJ's conclusion that *Rogan* is not on point. That case sets forth the procedural requirements of a valid closure under ORS 656.268(4)(a). Inasmuch as those requirements were not met in this case, the claim closure was premature.

In the Matter of the Compensation of
MARK A. STEDMAN, Claimant
WCB Case No. 98-04429
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's partial denial of claimant's current condition and "new medical condition" claims for L2-3 and L3-4 disc herniations and a chronic pain condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

After two and one-half days of operating an excavator, claimant's left leg began to tingle. His condition worsened, and, on March 29, 1994, he sought treatment from Dr. Glovinsky, osteopath. On April 13, 1994, an MRI revealed a left L4-5 herniated disc and a small neural canal and bony growth that combined to cause central spinal stenosis at L3-4 and L4-5. (Ex. 4). On May 4, 1994, the employer accepted a left L4-5 herniated disc. On May 12, 1994, Dr. Louie performed a microlumbar diskectomy at L4-5. (Ex. 13).

Claimant initially had good pain relief, and on August 22, 1994, Louie released him to regular work with a 50-pound lifting limit. (Exs. 18, 23, 26, 27, 28). On November 30, 1994, Louie noted residual leg pain and prescribed physical therapy (PT). (Ex. 29). On January 20, 1995, claimant missed a PT session because his back was "too sore" after slipping on his front porch a few days earlier. By January 23, 1995, claimant was back to his baseline status. (Ex. 32-9).

Claimant's symptoms continued to worsen, and, on February 16, 1995, he sought treatment from Dr. Purtzer, neurosurgeon. (Ex. 38). Tests showed lateral recess stenosis at L4-5 and a disc at L3-4 with lateral recess stenosis. (Ex. 46). On June 13, 1995, Purtzer performed a left L3-4 decompression and left L4-5 decompression with diskectomy. During surgery, Purtzer noted disc collapse at L4-5. (Ex. 48). On July 6, 1995, claimant complained of severe left leg pain after coughing. Purtzer diagnosed an acute disc herniation at L2-3. On July 17, 1995, claimant sought emergency room treatment for severe back pain and, on July 24, 1995, Purtzer performed a left L2-3 diskectomy and decompression. (Ex. 57).

On May 29, 1996, claimant was examined by Drs. Marble and Rich for the employer. The doctors opined that claimant's preexisting multi-level degenerative disc disease combined with the 1994 injury to create claimant's condition and need for treatment. (Ex. 67). Dr. Purtzer concurred. (Ex. 68).

Claimant continued to experience recurrent low back and leg pain. (Exs. 69, 71, 76, 78, 87). On February 11, 1997, Dr. Grant diagnosed chronic post-traumatic myofascial low back and left greater than right lower extremity pain syndrome. (Ex. 91). On May 13, 1997, Dr. Villaneuva, neuropsychologist, evaluated claimant's chronic pain syndrome; he diagnosed Pain Disorder with Medical and Psychological Features. (Ex. 79). On June 12, 1997, Drs. Rich, neurologist, and Smith, orthopedist, noted development of post-operative fibrosis and recommended a pain management program. (Ex. 97).

On December 18, 1997, Dr. Fuller, orthopedic surgeon, evaluated claimant for the employer. Fuller opined that claimant's preexisting congenitally small spinal canal and multi-level degenerative disc disease were the major cause of claimant's L2-3 and L3-4 low back conditions and need for treatment. (Ex. 110). Dr. Purtzer concurred. (Ex. 118, 121).

Dr. Richard Rosenbaum, neurologist, evaluated claimant for the employer on the same date. Rosenbaum opined that the major contributing cause of claimant's L3-4 and L2-3 low back conditions were the specific traumatic events of slipping on the porch in January 1995 and coughing in July 1995. He also opined that the L2-3 and L3-4 low back conditions are separable from the L4-5 condition, although he thought L4-5 condition may be making a minor contribution to the chronic pain condition. (Exs. 112, 114). Dr. Purtzer concurred. (Exs. 115, 118).

A May 15, 1998 Notice of Closure closed the claim with an award of 18 percent unscheduled permanent disability, which was reduced to 12 percent by an Order on Reconsideration. On June 2, 1998, the employer denied compensability of the L2-3 and L3-4 discs, the pain disorder, and claimant's current condition.

CONCLUSIONS OF LAW AND OPINION

As the ALJ found, only the opinion of Dr. Purtzer, claimant's current treating physician and surgeon, might support compensability of claimant's claim. The ALJ found Dr. Purtzer's opinion unpersuasive. Therefore, the ALJ concluded that claimant failed to prove compensability of his discs at L2-3 and L3-4, chronic pain syndrome, and current condition. We agree.

Claimant argues that the ALJ erred in rejecting Dr. Purtzer's deposition testimony regarding the cause of claimant's L2-3 and L3-4 discs. Specifically, claimant argues that Dr. Purtzer explained his changed opinions, and that his deposition testimony should be evaluated in light of all the medical evidence. Claimant further argues that the ALJ erroneously found that Dr. Purtzer was unaware of two non-industrial events that the employer's medical examiners found to play a causative role in claimant's back problems. Finally, claimant argues that Dr. Purtzer should be given the customary deference accorded to a treating doctor. We disagree. Even if we disregard any problems engendered by Dr. Purtzer's changed opinions, we find his opinion insufficient to meet claimant's burden of proof.

Claimant experienced a compensable injury to his low back on January 30, 1994. The employer accepted an L4-5 herniated disc, which was surgically treated by Dr. Louie. On June 13, 1995, Dr. Purtzer performed a left L3-4 decompression and left L4-5 decompression with diskectomy. A few weeks after surgery, claimant complained of increasing left leg pain after coughing. On July 17, 1995, claimant sought emergency room treatment for severe back pain, and, on July 24, 1995, Dr. Purtzer performed a left L2-3 diskectomy and decompression.

Dr. Purtzer concurred with a May 1996 opinion by Drs. Marble and Rich that claimant's degenerative disc disease, which preexisted the January 1, 1994 injury, combined with that injury to create claimant's then-current condition (*i.e.*, the L4-5, L3-4 and L2-3 discs) and need for treatment.

Claimant continued to experience recurrent low back and left leg pain, which was diagnosed as chronic pain disorder. A pain management program was recommended.

Dr. Purtzer also concurred with a December 1997 opinion by Dr. Fuller, orthopedic surgeon, who opined that claimant's preexisting congenitally small spinal canal and multi-level degenerative disc disease were the major cause of claimant's L2-3 and L3-4 low back conditions and need for treatment. In addition, Purtzer concurred with the opinion of Dr. Richard Rosenbaum, neurologist, who opined that the major contributing cause of claimant's L2-3 and L3-4 low back conditions were the specific traumatic events of slipping on the porch in January 1995 and coughing in July 1995. Rosenbaum also opined that the L2-3 and L3-4 low back conditions were separable from the L4-5 condition, although he allowed that the L4-5 condition might be making a minor contribution to the chronic pain condition.

Finally, on May 27, 1998, Dr. Purtzer concurred with a letter from the employer, indicating that, given the complexity of the conditions in claimant's lumbar spine, he was unable to identify, in terms of reasonable medical probability, the major contributing cause of the L2-3 and L3-4 disc herniations, and was unable to identify the major contributing cause of claimant's chronic pain disorder. (Ex. 118).

Because of the multiple possible causes of claimant's L2-3 and L3-4 disc herniations and chronic pain disorder, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *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, there are persuasive reasons not to defer to Dr. Purtzer's opinion.

First, Purtzer concurred with the examining physicians' opinions, none of which found that claimant's 1994 low back injury was the major contributing cause of his L2-3 and L3-4 disc herniations. But in May 1998, Purtzer stated that he was unable to identify the cause of any of the denied conditions

because of the complexity of the conditions in claimant's lumbar spine and was unable to determine, by reasonable medical probability, the cause of claimant's chronic pain syndrome. Although none of Purtzer's opinions benefit claimant in this case, Purtzer offered no explanation for his changed opinion.

During his deposition, Purtzer explained that his concurrences with the examining physicians were not in fact agreement in every particular, even though he did not express any reasons for his disagreements as provided in the concurrence letters. At the beginning of the deposition, Purtzer apparently agreed with his May 1998 position, stating that it was "ludicrous to say that everything is related to the injury," and that the injury was the inciting incident that developed the cascade of claimant's symptoms. (Ex. 125-13).

Purtzer explained that the complexity of the situation--a congenitally narrow canal, a ruptured disc, degenerative changes and changes due to the accident, and L5 neuritis from the radiculopathy--made it difficult to identify the major cause. He also stated that it was impossible to identify the cause from the surgery itself. (Ex. 125-15).

Further questioning ensued, and Purtzer's responses regarding causation remained equivocal. (*E.g.*, Ex. 125-33 through -46). At this point, Purtzer considered his surgical finding of a collapsed disc at L4-5 during his first surgery. Then he changed his opinion, stating that, as between the January 23, 1995 fall, the congenital stenosis, the L4-5 disk rupture and the bony formations, the most likely major contributing factor to the L4-5 surgery was the L4-5 disc rupture, and the probable "thing that set it off" was the original injury. (Ex. 125-46).

Purtzer also agreed that at least the part of the procedure performed in June 1995 on the L4-5 disc was necessitated by the January 1994 injury and ruptured L4-5 disc. (Ex. 125-51). Finally, Purtzer agreed that, "hypothetically," the L3-4 and L2-3 surgeries were more likely than not the result of the original work incident. (Ex. 125-51, -52). He also agreed that he was not aware of any significant factors other than the work accident that contributed to claimant's chronic pain condition. (Ex. 125-53).

To the extent that Purtzer's final medical opinion differed from his earlier agreement with the examining physicians and his statements regarding the difficulty in sorting out the major contributing cause of claimant's L2-3 and L3-4 herniated discs because of the complexity of claimant's low back conditions, we do not find his change of opinion to be persuasive. *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).

Even assuming that Purtzer's explanation regarding the surgical finding of a collapsed disc at L4-5 was related to the 1994 injury was correct, Purtzer's addition of the L2-3 and L3-4 discs to that analysis was conclusory and, as he admitted, merely hypothetical. As such, it is not a reasonable explanation for his change of opinion and is not persuasive. Finally, his earlier explanation that the injury was the "inciting incident" that developed the cascade of claimant's symptoms also fails to meet claimant's burden of proof. *Robinson v. SAIF*, 147 Or App 157 (1997); *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995); *Somers v. SAIF*, 77 Or App 259, 262 (1983) (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). For all the above reasons, we do not find Dr. Purtzer's causation opinion regarding the L2-3 and L3-4 discs persuasive.[1]

Finally, there is no medical opinion establishing that claimant's compensable injury or the accepted L4-5 disc is the major contributing cause of his current chronic pain condition.

ORDER

The ALJ's order dated February 23, 1999 is affirmed.

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[1] Whether Purtzer knew about the slipping incident in January 1995 or the coughing incident in July 1995 would have no effect on the outcome of the case.

In the Matter of the Compensation of
JO E. THOMPSON, Claimant
WCB Case No. 98-09639
ORDER OF DISMISSAL
Charles L. Lisle, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

The insurer requested review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's occupational disease claim for a left foot plantar fascia condition. The parties have submitted a proposed "Disputed Claim Settlement Pursuant to ORS 656.289(4)" that is designed to resolve all issues raised or raisable between them, in lieu of the ALJ's order.

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented in the agreement, "shall be reinstated and affirmed." The agreement further provides that the insurer's "Request for Board Review shall be dismissed with prejudice as to all issues raised or raisable."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to a "non-workers' compensation" insurance provider for reimbursement of bills and costs that it has paid on claimant's behalf. Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement (DCS), only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a DCS are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation insurance carrier will receive reimbursement *directly* from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of her share of the settlement proceeds to the non-workers' compensation carrier. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234.

In the Matter of the Compensation of
CHESTER D. WINTER, Claimant
WCB Case No. 98-08365
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that found that claimant had not perfected an aggravation claim. In his brief, claimant contends that his aggravation claim was properly perfected. On review, the issues are claim processing and aggravation. We affirm.

FINDINGS OF FACT

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

In May 1996, the insurer accepted claimant's claim for bilateral carpal tunnel syndrome (CTS). The claim was closed by a September 27, 1996 Determination Order that awarded no permanent disability.

On November 10, 1997, claimant returned to Dr. Jansen, his treating physician, complaining of loss of strength and coordination in his hands. Jansen measured decreased grip strength and found a mildly positive Tinel's test on the right. Jansen declined to file an aggravation claim and described claimant's current condition as symptomatic residuals from surgery. The insurer received a copy of the chart note on November 25, 1997. (Ex. 15).

On January 5, 1998, Dr. Jansen filed a Form 2837 giving notice of a claim for aggravation. On that form, Jansen indicated that time loss was not authorized. The insurer received the aggravation form on February 9, 1998. (Ex. 17).

On April 3, 1998, the insurer wrote to claimant's attorney stating: "[A] true aggravation has not been filed as there was [sic] no medical reports supporting an actual objective worsening of [claimant's] condition."

On October 22, 1998, claimant filed a request for hearing, raising the issues of a "de facto" aggravation denial, penalties and attorney fees. On December 11, 1998, the insurer cross-appealed, asserting that claimant had failed to perfect an aggravation claim and denying all relief requested. At hearing, the insurer moved for dismissal of claimant's hearing request on the basis that claimant had failed to perfect an aggravation claim.

CONCLUSIONS OF LAW AND OPINION

After convening a hearing on January 14, 1999, the ALJ concluded that claimant had failed to perfect an aggravation claim. Consequently, the ALJ dismissed claimant's hearing request as premature. On review, claimant contends that his aggravation claim was properly perfected and that the ALJ erroneously dismissed his hearing request.

Subject to ORS 656.319 (which sets time limits within which a claimant must request a hearing on a denial of a claim), "any party * * * may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute * * *". ORS 656.283(1). Under ORS 656.273(3), there are two essential elements for a "claim for aggravation": the completed Director's form and the accompanying attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury. *See Ted B. Minton*, 50 Van Natta 2423 (1998); *David L. Dylan*, 50 Van Natta 276, *on recon* 50 Van Natta 852 (1998); *see also Melvin L. Shroy*, 48 Van Natta 561 (1996).

Here, although claimant and Dr. Jansen submitted a completed Director's form to the insurer on January 5, 1998, the record fails to establish that the claim form was accompanied by the required written medical report. Dr. Jansen indicated on the Director's form that no time loss was authorized and we find no companion medical report documenting objective findings of a worsened condition attributable to the accepted bilateral carpal tunnel syndrome.

Indeed, even if we were to find that the aggravation claim form was "accompanied by" Dr. Jansen's November 10, 1997 chart note, this report fails to satisfy the statutory requirement. The chart note merely described claimant's complaints as "symptomatic residuals from the surgery," not as a "worsened" condition. Accordingly, we find that claimant's January 5, 1998 aggravation claim is procedurally defective.

Because we have found that claimant has not made a valid aggravation claim, the 90-day period provided the carrier to respond to a perfected aggravation claim has not been triggered. Accordingly, claimant's request for hearing on the alleged "de facto" aggravation denial is premature. ORS 656.273(3); ORS 656.262(7)(a); *Ronda G. Prewitt*, 49 Van Natta 831 (1997) (because the 90-day period allowed the carrier to respond to the perfected aggravation claim had not expired by the time of the hearing, it was premature to consider the merits of claimant's aggravation claim).

ORDER

The ALJ's order dated February 16, 1999 is affirmed.

July 28, 1999 Cite as 51 Van Natta 1356 (1999)

In the Matter of the Compensation of
RICHARD YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER OF ABATEMENT

Claimant requests reconsideration of our June 28, 1999 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
NICK J. FEDER, Claimant
Own Motion No. 97-0014M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander & Lebenbaum, Claimant Attorneys

Claimant requests review of the insurer's May 26, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from January 31, 1997 through May 12, 1999. The insurer declared claimant medically stationary as of May 12, 1999. 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 May 26, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

On May 12, 1999, Dr. Kaur-Jayaram, claimant's attending physician, reported that claimant was medically stationary and that no further surgery was necessary. He explained that the current treatment (biofeedback, stress management and other pain management strategies) were considered to be more palliative than curative in that, although such modalities might improve claimant's functionality, they would not improve his underlying compensable condition.

Claimant argues that, although Dr. Kaur-Jayaram classified his current treatment as "palliative," said treatment was designed to improve his functional ability and wean him off the use of pain medication. Thus, because his functional ability would improve with continued treatment, claimant argues that he was not medically stationary when the insurer closed his claim.

We have previously found that when treatment is designed to primarily improve a claimant's functional abilities, and not to improve his compensable condition, this treatment is not determinative when establishing his medically stationary status under ORS 656.005(17). *Kelly J. Trussell*, 47 Van Natta 121 (1995); *Frank M. Douglas*, 46 Van Natta 1445 (1994). In reaching our conclusions in *Trussell* and *Douglas*, we relied on *Clarke v. SAIF*, 120 Or App 11 (1993). In *Clarke*, the claimant argued that continued medical treatment designed to improve functionality supported the contention that the claimant was not medically stationary at closure. The court rejected this argument based on the following reasoning.

In *Clarke*, the claimant argued that although his treating physician declared him medically stationary, his need for a leg brace to support his weak leg supported his contention that he was not medically stationary until his leg was fitted for the brace and he was released from medical care. The court paraphrased the claimant's argument as an argument that "ORS 656.005(17) is not limited to medical treatment prescribed for improving his physical condition, but also encompasses treatment prescribed solely for the improvement of his functional abilities given a particular condition." *Clarke*, 120 Or App at 13. The court rejected that argument and held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary date under ORS 656.005(17)." *Id.* at 120 Or App 13-14. Because there was no evidence that the leg brace was prescribed to improve the claimant's physical condition, the court concluded that the claimant was medically stationary when the carrier closed his claim.

Here, certain modalities in the form of physical therapy, epidural injections and biofeedback strategies may improve claimant's functionality. However, as noted above, functional improvement alone is not pertinent to his medically stationary status. Instead, the deciding factor is that there is

evidence that such modalities are prescribed to improve claimant's compensable condition, *i.e.* his cervical disk injury. Without such evidence, and given Dr. Kaur-Jayaram's unrebutted opinion that claimant was medically stationary as of May 12, 1999, we find that claimant was medically stationary when the insurer closed his claim. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's May 26, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

August 3, 1999 Cite as 51 Van Natta 1358 (1999)

In the Matter of the Compensation of
PHYLLIS K. STOHR, Claimant
WCB Case No. C991793
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Member Biehl and Haynes.

On July 23, 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 $5,250 and the total due claimant's attorney is $1,750. This would equal a total consideration of $7,000. However, the total consideration (without reference to a distribution between claimant and her attorney) recited on the third page of the CDA is "$9,500" instead of $7,000. Finally, on page four, the total consideration, as well as the amounts payable to claimant and her attorney, are consistent with the first page.

Under such circumstances, we rely on those portions of the CDA that particularly describe the amounts payable to claimant and her attorney. Consequently, we are persuaded that the lone reference on page three of the CDA to a total consideration of $9,500 is a typographical error. Accordingly, we interpret the agreement as providing for a total consideration of $7,000, with $1,750 payable 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 $1,750, 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
ELVERA A. FOSTER, Claimant
WCB Case No. 98-06804
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

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

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

The insurer argues that the ALJ should not have relied on Dr. Waldram because the doctor's opinion was based a "temporal, precipitating cause analysis." (App. Br. at 2). While we agree that Dr. Waldram's opinion was based, in large part, on the fact that claimant did not have a significant, debilitating back condition until after the injury, Dr. Waldram also considered claimant's clinical presentation and the fact that the condition was unresponsive to therapy and conservative measures in determining that the injury was the major cause of claimant's need for treatment. Under such circumstances, we find that Dr. Waldram's opinion is not based solely on the temporal connection between the injury and claimant's condition.[1]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, 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), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 9, 1999 is affirmed. For services on Board Review, claimant's attorney is awarded $1,600, payable by the insurer.

[1] We also note that Dr. Waldram considered and discussed the relative contribution from claimant's preexisting condition and still concluded that the injury was the major contributing cause of claimant's need for treatment.

In the Matter of the Compensation of
ALFREDO R. HERRERA, Claimant
WCB Case Nos. 98-07437, 98-04174 & 98-01287
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Bock, Biehl, and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) upheld Liberty Northwest Insurance Company's denial, on behalf of Anodizing, Inc., of claimant's "new injury" claim for a thoracic strain; and (2) upheld Liberty's denial, on behalf of Waddles Restaurant, of claimant's aggravation claim for his back condition.[1] In its respondent's brief, Liberty / Waddles moves for dismissal of claimant's request for review, contending that it did not receive timely notice of his appeal.[2] On review, the issues are the motion to dismiss and compensability.

We deny the motion to dismiss claimant's request for Board review. Our conclusion is based on the following reasoning.

The ALJ's Opinion and Order issued on October 30, 1998. Parties to that order were claimant, Anodizing, Waddles, and their insurer (Liberty).

On November 30, 1998, the Board received claimant's request for review of the ALJ's order. Claimant's request, which was dated November 25, 1998, indicated that copies of the request had been mailed to Anodizing and to Liberty.[3]

Liberty / Waddles moves for dismissal of claimant's request for review. Asserting that Waddles' first notice of claimant's appeal occurred on December 3, 1998 (when it received a copy of the Board's letter acknowledging the appeal), Liberty / Waddles contends that claimant's request is defective under ORS 656.295(2). We disagree.

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(20). In the absence of prejudice to a party, timely service of a request for review on an employer's insurer is sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board. *King*, 63 Or App at 852; *Nollen v. SAIF*, 23 Or App 420, 423 (1975); *Juan A. Hernandez*, 47 Van Natta 2421 (1995); *Franklin Jefferson*, 42 Van Natta 509 (1990). A party's *receipt* of a copy of an appealing party's request for review is not determinative; rather, the pivotal issue is whether the request was timely *mailed* to the other party. *Jefferson*, 42 Van Natta at 509; *Judy W. Louie*, 47 Van Natta 383 (1995).

Here, the 30th day after the ALJ's October 30, 1998 order was November 30, 1998. Claimant's request for review represents that copies were mailed to Anodizing and Liberty on November 25, 1998.

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[1] Claimant also contests the ALJ's exclusion of proposed Exhibit 74. Because the result would be the same even if the excluded exhibit was considered, we decline to address the ALJ's evidentiary ruling.

[2] Liberty / Anodizing filed a cross-request for review, but withdrew that request in its respondent's brief. Despite its subsequent withdrawal of that appeal, Liberty / Anodizing continues to argue that claimant's request for review was defectively filed.

[3] No party challenges the representation contained in claimant's request for review that a copy of the request was mailed to Liberty and Anodizing on November 25, 1998 (which was within 30 days of the ALJ's October 30, 1998 order).

Although Liberty / Waddles argues that its "actual notice" of claimant's appeal did not occur until its December 3, 1998 receipt of the Board's acknowledgment letter, it does not challenge claimant's representation that a copy of the request for Board review was mailed to Anodizing and Liberty on November 25, 1998. In light of such circumstances, we find that, within 30 days of the ALJ's October 30, 1998 order, a copy of claimant's request for Board review was mailed to Anodizing and Liberty. *Id.*

Consequently, the question becomes whether timely service of claimant's request for review on Liberty is sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with this forum, even though Liberty's insured (Waddles) did not receive timely notice of the appeal. Based on the following reasoning, we hold that it does.

In *Nollen*, an "aggravation" insurer requested Board review of a then-Referee's responsibility decision. In doing so, the "aggravation" insurer sent copies of the request to the "new injury" insurer, but not to the "new injury" employer. Relying on ORS 656.295(2) (which provided then, as it does now, that "copies of the request [for review] shall be mailed to *all other parties*"), the "new injury" employer contended that the Board lacked appellate jurisdiction to consider the appeal. The *Nollen* court disagreed with the "new injury" employer's argument. Finding no prejudice to the "new injury" employer since it received actual notice of the appeal through the "new injury" insurer, the *Nollen* court determined that service on the "new injury" insurer was sufficient compliance with ORS 656.295(2) to vest appellate jursidiction with the Board.

At the time of the *Nollen* decision, "party" was defined as "a *claimant* for compensation, the *employer* of the injured workman at the time of injury or the State Accident Insurance Fund." *Former* ORS 656.002(17). Thus, the *Nollen* court was confronted with a situation where no "party" had received timely service of the "aggravation" insurer's request for Board review as required by ORS 656.295(2). Because notice of the appeal had been timely served on the "new injury" employer's insurer (an entity in privity with its insured), the *Nollen* court found sufficient compliance with ORS 656.295(2).

The current definition of "party" under ORS 656.005(21) has been expanded to include "*and* the insurer." Yet, since the *Nollen* holding, there has been no amendment to ORS 656.295(2) and its statutory construction of the phrase "all other parties" to include entities in privity with parties. In any event, as previously noted, there is no dispute that Liberty Northwest (the insurer) has received timely notice of the appeal. Thus, the jurisdictional issue confronted in the present case is identical to that posed in *Nollen*; *i.e.*, in the absence of prejudice to an un-served employer, is timely service of a copy of a request for Board review on its insurer sufficient compliance with ORS 656.295(2) when timely service of the appeal on the insurer's insured (*i.e.*, the employer) is not perfected?

The *Nollen* court answered that jurisdictional question in the affirmative. In doing so, the *Nollen* court was analyzing the question under a statutory scheme that did not include an "insurer" within the definition of a "party." Thus, no "party" had been timely served with notice of the appellant's request for Board review in *Nollen*. Yet, the *Nollen* court found sufficient compliance with the "notice" requirements of ORS 656.295(2) because the insurer (a "non-party" entity in privity with the employer) had received timely notice of the appeal.

Here, the essential facts are identical with one definitional difference. That difference is that the timely-served insurer is now a "party" under the current statutory scheme. We can detect nothing in the *Nollen* court's reasoning that would suggest that appellate jurisdiction would be lacking had the then-existing statutory system included an insurer as a "party." Consequently, we conclude that the *Nollen* court's construction of ORS 656.295(2) is both applicable and controlling.[4] We further note that this statutory construction has been consistently applied in a number of Board decisions. *See Hernandez*, 47 Van Natta at 2421; *Jefferson*, 42 Van Natta at 509.

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[4] We acknowledge that the court has ruled that the failure to timely file and serve *all parties* with a request for Board review as required by ORS 656.295(2) requires dismissal of the appeal. *Kelsey v. Drushella-Klohk, NCE*, 128 Or App 53 (1994); *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992); *King*, 63 Or App at 52-53. Yet, in each of those appellate decisions, the appealing party had neither provided timely notice of the appeal to the other party nor to any person or entity in privity with that "non-served" party. *Id.* Inasmuch as none of those decisions addressed the precise question answered in *Nollen* and presented in this case (*i.e.*, whether timely service of an appeal on an insurer in privity with a "non-served" employer is sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board), they do not alter the *Nollen* holding and its precedential interpretation of ORS 656.295(2).

In conclusion, it is undisputed that Liberty is the insurer for both Anodizing and Waddles. Furthermore, there is no contention that Waddles was prejudiced by its untimely actual notice of claimant's appeal.[5] As with the employer's insurer in *Nollen*, Waddles' insurer (Liberty) received timely notice of the appeal and Waddles has appeared in this proceeding to move for dismissal of claimant's appeal (as well as filing a respondent's brief).[6] Under such circumstances, we hold that claimant's timely service of his appeal on Liberty, a party in privity with Waddles, constitutes sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board. Accordingly, the motion to dismiss is denied.[7]

Turning to the merits of claimant's appeal, we adopt and affirm the ALJ's order.

ORDER

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

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[5] We agree with the dissent's observation that the *Nollen* holding stands for the proposition that, in the absence of prejudice to a non-served employer, timely service of an appeal on the insurer satisfies the jurisdictional requirements of ORS 656.295(2). Consistent with that rationale, because the record does not support a conclusion that Waddles was prejudiced by its failure to receive actual notice of claimant's request for Board review, claimant's timely service of the request on Liberty is sufficient to vest appellate jurisidiction with this forum.

In reaching this conclusion, we disagree with the dissent's contention that the *King* court's reasoning "brings the [*Nollen*] case into question." First, as acknowledged by the dissent, the *King* court does not disavow the *Nollen* holding. As the *King* court reminds us, if a prior decision is wrong, "it is for this court or the Supreme Court to say so." *King*, 63 Or App 853, n. 2. In light of such an admonition, we are disinclined to follow the dissent's stated course and refrain from applying a controlling authority that has not been overruled.

Moreover, the holdings of the *King* and *Nollen* courts are entirely consistent. In this regard, the *King* court expresses no disagreement with the basic proposition advanced in *Nollen*, describing the *Nollen* decision as "involv[ing] the failure to comply with notice requirements in the sense that the party requesting review did not send notice to the other parties *but instead sent timely notice to a person or entity in privity with the party.*" *King*, 63 Or App 852 (Emphasis supplied). It is this latter fact that the *King* court found distinguishable from *Albiar v. Silvercrest Industries*, 30 Or App 281 (1977), which was the holding that the court applied in concluding that "when actual notice of a request for review is received after the time for giving notice has expired, prejudice is not a relevant consideration." *King*, 63 Or App 852. In other words, in *King*, it was undisputed that the appealing claimant "never sent copies of the request [for Board review] to the other parties." *King*, 63 Or App 850. Thus, when actual notice of the appeal was untimely provided, the *King* court determined that the question of prejudice was not a relevant consideration. As distinguished in *King*, the *Nollen* decision involved timely notice to a person or entity in privity with a non-served party. Considering that pivotal distinction, the *King* court's rejection of consideration of a "prejudice" question are confined to those situations where the appealing party has failed to provide timely actual notice to any of the other parties. Consistent with the *King* court's reasoning, the *Nollen* court's consideration of the "prejudice" question is appropriate in cases where timely notice of an appeal has been provided to a person or entity in privity with the non-served party. Because the case at hand presents the precise issue posed in the *Nollen* decision, our consideration of the "prejudice" question is consistent with both the *King* and *Nollen* holdings.

[6] The dissent raises a distinction between the case at hand and the circumstances presented in *Nollen*, noting that in this case it is unclear whether Liberty was served with a copy of claimant's request for review in its specific capacity as the insurer for Waddles. We do not consider this distinction to be determinative. Rather, as previously discussed, the pivotal point is timely service of claimant's appeal on Liberty. In its dual capacity as the insurer for both employers, such service establishes timely notice of claimant's request for review on each of Liberty's insureds.

[7] In reaching this conclusion, we acknowledge that claimant's request did not indicate that a copy had been mailed to the attorneys for Anodizing / Liberty and Waddles / Liberty. Thus, it appears that claimant neglected to comply with OAR 438-011-0005(2). Nonetheless, this apparent violation of the Board's administrative rule does not constitute a jurisdictional defect and does not result in the dismissal of a party's request for review. *Charlotte M. Soros*, 50 Van Natta 2072, *on recon* 50 Van Natta 2233 (1998).

Board Member Haynes dissenting.

I disagree with the majority's holding "that claimant's timely service of his appeal on Liberty, a party in privity with Waddles, constitutes sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board." Because I would grant the motion to dismiss Liberty/Waddles from this case, I dissent.

The hearing included two employers: Waddles and Anodizing, Inc. Liberty insured both employers. Claimant's request for review, however, referred only to "Anodizing, Inc." as the employer. The request for review also showed Anodizing was the only employer that was sent a copy of the request for review. Thus, as the majority recognizes, Waddles did not receive timely service of the request for review.

The majority's holding relies principally on *Nollen v. SAIF*, 23 Or App 420 (1975). In that case, two carriers respectively insured two employers. The carrier found responsible at hearing sent the request for review to the nonresponsible carrier but not the nonresponsible employer. In holding that service on the nonresponsible carrier sufficiently complied with the statute,[1] the court stated that:

> "such service satisfied the necessary function of notice statutes: that of informing the parties of the issues in sufficient time to prepare for adjudication. Here, notice to [the nonresponsible carrier] fulfilled this requirement. The same attorney represented both [the nonresponsible carrier] and the employer before the referee. * * * In this case we see no prejudice to employer since it received actual notice of the appeal through [the nonresponsible carrier]." 23 Or App at 423-24.

Here, after determining that "the *Nollen* court's construction of ORS 656.295(2) is both applicable and controlling," the majority holds that, because Liberty was a party in privity with Waddles, service on Liberty was sufficient to satisfy the statute.

I disagree with this analysis. Although the facts in *Nollen* are similar, I do not find them to be indistinguishable from this case. In *Nollen*, there was no dispute that the nonresponsible carrier was served, thus supporting the court's subsequent decision that the nonresponsible employer received actual notice. Here, although Liberty clearly received a copy of the request for review, it is not obvious to me that it did so as the carrier for *Waddles*. Rather, because only Anodizing was referenced, it seems more likely that it received service as the carrier for *Anodizing*. In sum, I find it questionable that Liberty, as a party in privity with Waddles, was served with the request for review.

I also disagree that *Nollen* necessarily "is both applicable and controlling." In *Argonaut Ins. Co. v. King*, the claimant failed to send a copy of the request for review to the carrier, Argonaut. The court further found that Argonaut did not have actual notice of the request for review within the 30-day period and it was not prejudiced by the lack of notice.

In deciding whether the Board had jurisdiction to review the case, the court discussed several previous cases, including *Nollen*, where the court had held that a party's failure to comply strictly with notice requirements did not preclude the reviewing body from exercising jurisdiction in the absence of prejudice to the other parties.[2] The court further characterized these cases as holding that "the notice, although defective, was sufficient in the absence of prejudice." 63 Or App at 867.

The court then rejected claimant's argument that it should follow this line of cases and instead held that, "when actual notice of a request for review is received after the time for giving notice has expired, prejudice is not a relevant consideration." *Id.* The court further stated that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." *Id.* Because Argonaut had not received actual notice within the 30-day period, the court concluded that the Board lacked jurisdiction.

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[1] At that time, ORS 656.295(2) required that copies of the request for review be mailed to "all other parties to the proceeding[.]" "Party" included the claimant, "the employer of the injured workman at the time of injury or the State Accident Insurance Fund [SAIF]." *Former* ORS 656.002(17).

[2] Specifically, the court stated that *Nollen* "involved the failure to comply with notice requirements in the sense that the party requesting review did not send notice to the other parties but instead sent timely notice to a person or entity in privity with the party." 63 Or App at 867.

I agree with the majority that *Nollen* has not been expressly overturned. But I believe that *King's* discussion of the case and its express holding that the statute requires that the notice be mailed or actual notice be received within the 30-day period brings the case into question. Because the court's discussion in *Nollen*, and *King*'s treatment of the case, both indicate that its holding relied upon the absence of prejudice, and the *King* case clearly held to the contrary, I believe it to be more consistent with current case law to determine whether the request for review was mailed or actual notice received within the statutory period.[3] Consequently, rather than relying on *Nollen*, I would determine whether or not Waddles itself had actual notice of the appeal within the 30-day period.

As the majority states, Waddles did not timely receive a copy of the request for hearing. Furthermore, the record does not show that it had timely actual notice of the appeal. Consequently, I would grant the motion to dismiss it from this proceeding.

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[3] I note that the appellate courts last cited to *Nollen* in *King*, a 1983 case, where, as explained above, it declined to apply *Nollen* and find that, in the absence of prejudice, notice was sufficient under the statute. Furthermore, those cases subsequent to *King* consistently hold that, unless the nonserved party has timely actual notice of the request for review, failure to timely serve any "party" requires dismissal of that party. *E.g., Mosley v. Sacred Heart Hosp.*, 113 Or App 234 (1992).

In the Matter of the Compensation of
JEAN P. ELLIOT, Claimant
WCB Case No. 98-02026
ORDER OF DISMISSAL
Juli Point, Claimant Attorney
Brian L. Pocock, Defense Attorney

The self-insured employer requested review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's current right mid-foot condition. The parties have submitted a proposed "Disputed Claim Settlement Agreement" to resolve all issues raised or raisable between them, in lieu of the ALJ's order.

Pursuant to the settlement, the parties agree that the employer's denial of claimant's right mid-foot condition, "as supplemented by the contentions of the employer in paragraph (7) * * * will be affirmed and will remain in full force and effect forever." The agreement also provides that claimant's "Request for Hearing thereon is hereby dismissed with prejudice."

We approve the parties' settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] In granting this approval, we note that the agreement also provides that claimant "agrees to indemnify and hold harmless" the other parties regarding claims "arising out of claimant's employment * * * generally or in regard to this specific workers' compensation claim." Because our authority is confined to workers' compensation matters under ORS Chapter 656, our approval of the parties' settlement does not extend to any matters in the agreement that pertain to employment rights.

In the Matter of the Compensation of
RONALD L. CLARK, Claimant
Own Motion No. 93-0660M
OWN MOTION ORDER ON RECONSIDERATION REVIEWING CARRIER CLOSURE
Hollander, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our December 16, 1998 Own Motion Order Reviewing Carrier which affirmed the SAIF Corporation's October 9, 1998 Notice of Closure. With his request for reconsideration, claimant contends that because his physician recommended surgery for his compensable injury, his claim was prematurely closed. Based on the following reasoning, we continue to adhere to our prior order and affirm SAIF's Notice of Closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the October 9, 1998 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In our December 16, 1998 Order we found that, although Dr. Patterson, claimant's attending physician, recommended two additional surgeries, he also reported that before attempting either surgery, claimant needed to undergo a "significant weight reduction." Absent such weight loss, Dr. Patterson remained firm in his opinion that claimant was medically stationary.

Claimant was advised to lose weight on several occasions, but did not comply with the doctor's recommendations. Prior to the issuance of our December 1998 order, claimant submitted a November 17, 1998 affidavit wherein he attested that he had lost weight and had even demonstrated said weight loss to Dr. Patterson during an August 25, 1998 examination. However, we found that, claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980). Claimant did not (and has not) provide a *medical opinion* that would support his contention that he had lost weight and was ready to undergo the recommended surgery.

Claimant now argues that despite Dr. Patterson's position that he needed to lose weight before undergoing the recommended surgery, the fact that need for further surgery to materially improve his condition, is sufficient proof that he was not medically stationary at the time his claim was closed. Claimant relies on *Jack O. Pichette*, 41 Van Natta 2136 (1989), *Bill Davis*, 47 Van Natta 219 (1995) and *Jeannie L. Weakley*, 42 Van Natta 2388 (1990), to support his contentions. His reliance on the referenced cases is misplaced.

In *Pichette* and *Weakley*, claimants' physicians opined that material improvement of the claimants' compensable conditions was being delayed as a result of their being overweight. Thus, the physicians opined that there was a reasonable expectation that claimants' compensable conditions would improve through a weight loss program . As a result, we held that the weight loss programs were a compensable portion of the claimants' claims. Here, unlike the circumstances in *Pichette* and *Weakley*, Dr. Patterson is not of the opinion that claimant's overweight has been prolonging his disability and that he *needed* to be in a medically supervised weight loss program. Rather, Dr. Patterson *recommended* that claimant undergo a significant weight loss before attempting further surgery. Dr. Patterson declared that claimant was medically stationary until the *recommended* weight reduction was attained.

In *Davis*, we held that if postponement (as opposed to refusal) of surgery was beyond the claimant's control and was medically necessary for the compensable condition, the claim was closed prematurely since, at closure, there was still a reasonable expectation for improvement based on the surgery recommendation (although claimant's physician opined that claimant required surgery for one of

his compensable conditions prior to claim closure, claimant was subsequently referred to another physician to perform surgery, thus delaying the surgery). That case is distinguishable from the present case in that, here, the "postponement" of claimant's surgery is due to his failure to lose weight as recommended by Dr. Patterson. Claimant has not provided documentation (medical or otherwise) which would demonstrate that he has been unsuccessful in losing weight despite any attempts to do so and that his inability to lose weight is beyond his control.

Therefore, based on Dr. Patterson' unrebutted opinion, we continue to find that claimant was medically stationary when SAIF closed his claim.[1] Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 16, 1998 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] As we noted in our prior order, if claimant's compensable condition worsens to the extent that surgery and/or inpatient hospitalization is eventually *required*, he may again request reopening of his Own Motion claim for the payment of temporary disability. *See* ORS 656.278(1).

In the Matter of the Compensation of
TERRY L. ROHDE, Claimant
WCB Case No. C991813
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Daniel M. Spencer, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Biehl And Bock.

On July 26, 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 July 26, 1999. The statutory 30th day following the submission is August 26, 1999. Claimant filed his request for disapproval of the disposition on July 27, 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
WILLIAM C. HUNTER, Claimant
WCB Case No. 98-04706
ORDER ON REVIEW
Moscato & Hallock, 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) Hoguet's order that: (1) set aside its denial of claimant's occupational disease claim for a transient mucus membrane/upper respiratory tract irritation; and (2) awarded an assessed fee of $4,500. Claimant cross-requests review of that portion of the ALJ's order that declined to award penalties and attorney fees for an 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 regarding the compensability and attorney fee issues.

Compensability

The ALJ set aside the employer's denial of claimant's upper respiratory condition based on the medical report of Dr. Bardana, an examining physician who concluded on December 18, 1998 that claimant's work exposure was the major contributing cause of claimant's need for treatment and that the disputed condition was a direct result of claimant's work environment. (Ex. 34).

On review, the employer contends that Dr. Bardana's December 1998 opinion is inconsistent with the conclusions in his prior reports. Thus, the employer asserts that the ALJ incorrectly relied on Dr. Bardana's opinion in finding that claimant satisfied his burden of proving a compensable occupational disease claim. For the following reasons, we disagree with the employer's contentions.

While Dr. Bardana's initial reports were less definitive than the final December 1998 report, we agree with the ALJ's conclusion that, as a whole, Dr. Bardana's reports are not inconsistent. In his first report of April 2, 1998, Dr. Bardana described his diagnosis of "resultant transient annoyance and/or transient irritational mucous membrane and respiratory tract irritation" as a "work-related" problem. (Ex. 28D-18, 20). Dr. Bardana also noted that claimant was capable of returning to work provided that he was placed in an area free of fiberglass and other particulates "which were causing some transient symptoms." (Ex. 28D-21).

In a subsequent May 12, 1998 report, Dr. Bardana noted that claimant's "problem was multifactorial." (Ex. 30A). Dr. Bardana further opined that fiberglass was a "part of the problem, but not all of it." (Ex. 30A-2).

As previously noted, Dr. Bardana further refined his opinion in his December 1998 report and directly linked claimant's upper respiratory condition to the work environment, specifically fiberglass particulates. (Ex. 34-1). Accordingly, what the employer views as inconsistency we interpret as gradual refinement of an opinion on a difficult medical causation question. Therefore, we do not accept the employer's argument that Dr. Bardana's opinon should be discounted for alleged inconsistency.

The employer also argues that the opinion of Dr. Kelley, a consulting physician, should be given greater weight than Dr. Bardana's because Dr. Kelley was an attending physician. We disagree. Dr. Kelley testified at hearing that he evaluated claimant's condition on referral from Dr. Azhar, claimant's primary care physician, and that he never assumed care as claimant's primary treating physician. (Tr. 139). On this record, we decline to give Dr. Kelley the deference usually accorded an attending physician's opinion. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983).

Attorney Fees

The employer contends that the ALJ's attorney fee award of $4,500 is excessive. We disagree.

On *de novo* review, we consider the amount of an attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the

interest involved; (4) the skill of the attorneys; (5) the nature of the proceeding; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The issues in dispute were compensability of claimant's pruritic dermatitis and upper respiratory conditions. Claimant did not prevail with respect to the dermatitis condition. Approximately 45 exhibits were admitted into evidence, with two medical reports obtained by claimant's counsel. The hearing began at 9 a.m. and concluded after 4 p.m. and generated 171 pages of transcript. Claimant and two expert witness testified (Drs. Kelley and Burton).

When compared with other compensability disputes reviewed by this forum, we find that the case involved issues of above average medical complexity. The claim's value and benefits were comparable with those generally presented to this forum. The parties' respective counsels presented their positions in a thorough, skillful manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,500 is a reasonable and appropriate attorney fee for services at hearing.[1] In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, and considering that claimant did not prevail with respect to one condition), the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. Claimant is not entitled to an attorney fee for services related to the attorney fee and penalty issues. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 461 (1986).

ORDER

The ALJ's order dated February 8, 1999, as reconsidered on March 4, 1999, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the employer.

[1] In reaching this conclusion, we reject claimant's attorney's contention that his fee should be increased to $6,000.

In the Matter of the Compensation of
DALE A. KIBBLE, Claimant
WCB Case No. 97-10233
ORDER ON REMAND
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's July 22, 1999 amended order, we have been directed to consider the parties' settlement. The parties have submitted a proposed "Stipulation and Order" to resolve the attorney fee issue in dispute before the Court of Appeals.

Pursuant to the stipulation, the parties agree that SAIF will pay an assessed attorney fee of $2,750, in lieu of the $3,000 assessed attorney fee ordered by the Board's February 26, 1999 Order on Review. The parties further agree that the remainder of the Order on Review "shall remain affirmed." Finally, the stipulation provides that "SAIF has withdrawn its Petition for Judicial Review" and that "the matter is dismissed with prejudice."

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

IT IS SO ORDERED.

August 6, 1999 Cite as 51 Van Natta 1369 (1999)

In the Matter of the Compensation of
RONALD L. SINGLETON, Claimant
WCB Case No. 98-04403
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Bock and Phillips Polich.

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

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

The ALJ set aside the employer's denial, finding that claimant's disc herniation at L4-5 was caused in major part by a stepping incident on February 28, 1998. In doing so, the ALJ found persuasive the medical opinion of Dr. Van Pett, claimant's attending physician and neurosurgeon, who opined that the stepping incident was the major factor in the disc herniation.

On review, citing *Brown v. A-Dec, Inc.*, 154 Or App 244 (1998), the employer contends that the ALJ wrongly excluded claimant's disc desiccation (the normal age-related drying out of an intervertebral disc) as a causal factor in his disc herniation because the ALJ incorrectly concluded that it was not a "preexisting condition" under ORS 656.005(24).[1] Moreover, the employer asserts that Dr. Van Pett did not weigh the relative contribution of this condition to claimant's need for treatment. We do not find the employer's contentions persuasive for the following reasons.

In *Brown*, the court held that an age-related degenerative cervical condition qualified as a "preexisting condition," despite the claimant's contention that, because the degenerative condition was caused by the natural process of aging, it was not a disease. The court reasoned that there was no indication that ORS 656.005(24) was intended to exclude naturally occurring diseases. In addition, the court noted that the physicians in the case had characterized the degenerative process in the claimant's back as a "disease" and that there was no question that the condition contributed or predisposed the claimant to her need for treatment. 154 Or App at 248.

Unlike *Brown*, however, we are not persuaded, based on our review of Dr. Van Pett's persuasive deposition testimony, that the alleged preexisting condition in this case contributed or predisposed claimant to her need for treatment for the disc herniation. In fact, Dr. Van Pett testified, when asked if the desiccation of the disc was a predisposing factor: "No. It is not a clearly predisposing factor to disc herniation that we know." (Ex. 26-18). Moreover, we further find, based on Dr. Van Pett's testimony, that the disc dessication did not contribute to claimant's disability or need for treatment. Accordingly, because ORS 656.005(24) requires a contribution or predisposition to disability or the need for treatment, we find that the medical evidence does not establish that the disc desiccation here qualifies as a "preexisting condition" under the statute. *Cf. SAIF v. Cessnun*, 161 Or App 367 (1999) (in occupational disease claims, a disease or condition is "preexisting" if it contributes or predisposes the claimant to disability or a need for treatment and precedes either the date of disability or the date when medical treatment is first sought).

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[1] ORS 656.005(24) defines "preexisting condition" as:

"any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for worsening pursuant to ORS 656.273."

Alternatively, even if this condition did constitute a "preexisting condition," we are persuaded that Dr. Van Pett sufficiently considered the potential contribution of it to claimant's disc herniation both before and during the deposition. (Exs. 22; 26: pps. 17-19); *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). Therefore, we agree with the ALJ that claimant sustained his burden of proof.[2] Thus, we affirm.

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

ORDER

The ALJ's order dated March 19, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

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[2] The employer also questions claimant's credibility with respect to his descriptions of the alleged incident of injury. After reviewing the various accounts of claimant's stepping injury, we, like the ALJ, do not find the variations in those descriptions to be of sufficient magnitude so as to seriously undermine claimant's credibility or the histories on which the medical evidence was based.

In the Matter of the Compensation of
ALEXANDER TONIATTI, Claimant
WCB Case No. 98-04984
ORDER ON REVIEW
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that dismissed his request for hearing. With his appellate briefs, claimant has submitted additional documents and requests that the matter be remanded for consideration of those documents. On review, the issues are remand and dismissal. We decline to remand and affirm the ALJ's order.

FINDINGS OF FACT

On October 8, 1998, ALJ Thye issued an order upholding the employer's denial of claimant's occupational disease claim for a chronic lung condition. ALJ Thye's order stated that the "Issues" at hearing included a May 30, 1997 "de facto" denial and a June 15, 1998 written denial.

According to statements at hearing by the ALJ in this case, the Hearings Division assigned a new case number for the June 15, 1998 written denial and scheduled a new hearing to litigate that denial. The ALJ further stated that, prior to the new hearing, claimant, through his then-attorney, moved to dismiss the case.

By Notice of Hearing dated November 20, 1998, the matter was set for hearing on January 29, 1999 at the Workers' Compensation Board, Hearings Division, Suite 340 800 NE Oregon Street, Portland, Oregon. The Notice of Hearing was mailed to claimant at his last known address of 6645 Goldfield Dr., Colorado Springs, Colorado 80911. The Notice of Hearing was not returned by the U. S. Postal Service as undeliverable.

A hearing convened on January 29, 1999. Claimant was not present nor was a representative of claimant. Claimant's non-appearance was unexplained. Counsel for the employer appeared at the hearing.

On February 9, 1999, the ALJ issued a "Dismissal Order" that dismissed claimant's request for hearing on the basis the "the issues raised by the request for hearing in this matter have been litigated in prior litigation" and "based upon claimant's failure to appear and otherwise prosecute his claim[.]"

On March 1, 1999, the Board received claimant's February 22, 1999 letter requesting review of the ALJ's dismissal order.

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's request for hearing on the basis that "the issues raised by the request for hearing in this matter have been litigated in prior litigation" and "based upon claimant's failure to appear and to otherwise prosecute his claim[.]" We agree that dismissal of claimant's hearing request is warranted. However, we base our decision on the following reasoning.

Claimant has the burden of proving that the dismissal order was not appropriate. *Harris v. SAIF*, 292 Or 683, 690 (1992); *Donald J. Murray*, 50 Van Natta 1132 (1998). Where a claimant signs a retainer agreement employing an attorney and giving that attorney the authority to act on claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *Robert S. Ceballos*, 49 Van Natta 617 (1997); *Gilberto Garcia-Ortega*, 48 Van Natta 2201 (1996).

On December 9, 1998, following the issuance of ALJ's Thye's order (upholding the self-insured employer's denial of claimant's chronic lung condition), claimant's then-attorney requested dismissal of the instant case on the basis that ALJ Thye's order had decided the issue. The retainer agreement between claimant and his then-attorney authorized the attorney to act on claimant's behalf. Claimant does not assert that his then-attorney did not request dismissal of the hearing request. Nor does he assert that he was not represented by his then-attorney at the time in question.

Under these circumstances, we find no reason to alter the dismissal order. *Donald J. Murray*, 50 Van Natta at 1133; *William A. Martin*, 46 Van Natta 1704 (1994).[1]

ORDER

The ALJ's order dated February 9, 1999 is affirmed.

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[1] Inasmuch as we have affirmed the ALJ's dismissal, we need not address claimant's request to remand this matter for the submission of further evidence.

In the Matter of the Compensation of
FERRIN J. BARR, Claimant
WCB Case No. 98-08147
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
VavRosky, et al, Defense Attorneys

On July 9, 1999, we abated our June 10, 1999 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order upholding the self-insured employer's denial of claimant's soft-tissue neck and upper back condition, degenerative disc disease of the cervical spine and right-sided cervical disc protrusion at C5-6. We took this action to consider claimant's motion for reconsideration. Having received the employer's response, we proceed with our reconsideration.

To begin, we briefly recap the pertinent facts. Claimant, age 38 at the time of hearing, previously worked as a professional wrestler. He began working for the employer as an operating technician in 1994. In December 1997, claimant was involved in a noncompensable motor vehicle accident, during which he hit his head against the vehicle's door. He sought treatment and was diagnosed with a cervical strain/sprain, severe cervical degenerative disc disease and post-concussion syndrome. Although he was able to work, claimant continued to experience ongoing cervical symptoms.

Between January 1998 and April 1998, claimant treated with Dr. Milam, a chiropractor. In May 1998, claimant was referred to Dr. Ceballos for pain management. On May 18, 1998, Dr. Ceballos found five trigger points and injected each. He advised claimant to call back in 10 days to determine whether further treatment was necessary.

On May 26, 1998, claimant was struck in the right side of his neck by a heavy steel bar during the course and scope of his employment. Although momentarily dazed, he returned to his work duties. A while later, claimant noted some blood on his neck and was taken for emergency treatment. The emergency room physician stitched up a 2cm laceration and noted abrasion and mild swelling of the neck. He found no underlying structural involvement. An x-ray of the cervical spine showed claimant's marked degenerative changes but no acute changes.

Claimant returned to work after the emergency room visit. He continued to experience cervical symptoms and sought follow up treatment with Dr. Ceballos on June 11, 1998. Dr. Ceballos noted that claimant was "doing terrific except that he got a new trauma on the neck" that caused a recurrence of neck pain. Dr. Ceballos noted three new trigger points on the right side of the neck.

Claimant saw Dr. Milam on June 26, 1998, who noted that claimant's pain was improving. Dr. Milam recommended one or two more sessions with Dr. Ceballos. Dr. Milam did not mention claimant's May 26, 1998 injury. Claimant sought treatment from Dr. Ceballos on July 2 and July 17, 1998.

On July 20, 1998, the employer accepted a neck contusion and laceration arising out of the May 26, 1998 incident.

Claimant saw Dr. Milam for a closing examination concerning the December 1997 motor vehicle accident on August 10, 1998. He found claimant medically stationary with permanent impairment due to loss of cervical range of motion. Dr. Milam did not discuss claimant's May 26, 1998 injury, but did opine that, because of claimant's history of concussions as a professional wrestler and his underlying degenerative cervical spondylosis, claimant would experience chronic neck and back pain in the years to come.

Claimant returned to Dr. Ceballos in mid-August for another treatment. Around this same time, claimant began experiencing pain radiating into his right upper arm. An August 27, 1998 MRI was interpreted as showing a moderate right disc protrusion at C5-6 with mild cord deformity.

On October 2, 1998, claimant was examined by Dr. Farris at the employer's request. Dr. Farris opined that it was possible, although unlikely, that claimant's disc protrusion was caused by the May 26, 1998 injury. Instead, Dr. Farris concluded that, on a more likely than not basis, the cervical disc protrusion was due to claimant's preexisting degenerative condition or his prior injuries. After receiving

Dr. Farris' report, the employer issued a partial denial, denying claimant's soft tissue neck condition, soft tissue upper back condition, preexisting degenerative disc disease of the cervical spine and right sided disc protrusion at C5-6.

In December 1998, claimant was evaluated by Dr. Rosenbaum at the employer's request. Like Dr. Farris, Dr. Rosenbaum related claimant's cervical disc condition to his preexisting condition rather than the incident of May 26, 1998. Dr. Rosenbaum also questioned whether the MRI image showed a true protrusion or a continuation of the degenerative process and a "hard disk."

Drs. Milam and Ceballos subsequently related claimant's cervical disc protrusion to the May 26, 1998 incident because claimant did not have radicular symptoms until after this incident.

The ALJ concluded that, despite the opinions of Drs. Milam and Ceballos supporting the compensability of claimant's cervical disc condition,[1] claimant had not sustained his burden of proof. Specifically, the ALJ determined that the opinions of Drs. Milam and Ceballos were less persuasive than the contrary opinions of Drs. Farris and Rosenbaum. By adopting and affirming the ALJ's order, we found that the ALJ's order correctly applied the law and reached the appropriate result under the facts presented in the record. *See e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997) (by adopting an ALJ's order, the Board agrees with the facts and conclusions contained in the ALJ's order and considers the ALJ's order to be sufficient for appellate review).

On reconsideration, we adhere to our determination that the opinions of Drs. Milam and Ceballos are insufficient to sustain claimant's burden. First, unlike Dr. Farris, neither Dr. Milam nor Dr. Ceballos addressed the fact that claimant's radicular symptoms developed three months after the May 1998 incident.[2] Also, neither physician addressed Dr. Rosenbaum's contention that the abnormality noted on the imaging study may have represented a continuation of the degenerative process and a "hard disk" rather than a disc protrusion due to a traumatic event. Furthermore, the causation opinions of Drs. Milam and Ceballos are based largely on the temporal relationship between the May 26, 1998 incident and the onset of claimant's radicular symptoms[3] and do not sufficiently weigh the relative contribution of claimant's preexisting degenerative condition and prior injuries from wrestling and the motor vehicle accident. *See Allie v. SAIF*, 79 Or App 284, 288 (1986) (finding medical opinion based on chronology of events unpersuasive); *James S. Modesitt*, 48 Van Natta 2542 (1996) (treating surgeon's opinion found unpersuasive where he relied on a temporal relationship without sufficiently weighing the relative contributions from the preexisting degenerative condition and the alleged injury).

Moreover, we find that the causation opinions of Drs. Milam and Ceballos are not consistent with their contemporaneous chart notes. For example, as noted above, Dr. Milam did not mention the May 26, 1998 incident in his August 1998 closing examination. Nevertheless, at that time, he found claimant medically stationary without loss of motion but no neurological deficits. Dr. Milam attributed claimant's condition at that time to the December 1997 motor vehicle accident and his prior history of neck injuries and degenerative cervical disc disease.

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[1] Drs. Milam and Ceballos were the only physicians who related claimant's cervical condition to the May 1998 work injury. Dr. Fetchel, who treated claimant prior to the work incident, declined to offer an opinion because he did not have all of claimant's medical records. (Ex. 40). And although Dr. Woods, who saw claimant on one occasion in August 1998, did not fully concur with Dr. Rosenbaum's report (because it did not include a diagnosis of post-concussion syndrome secondary to the December 1997 motor vehicle accident), he also did not render any opinion as to the cause of claimant's cervical condition.

[2] Dr. Farris found it significant that claimant did not complain of right sided radicular pain for approximately three months after the May 26, 1998 injury. Dr. Farris opined that, considering claimant's severe preexisting disc disease at C5-6 and the fact that his symptoms following the May 26, 1998 incident were a continuation of the symptoms he had been experiencing prior to the incident, it is medically probable that the May 28, 1998 incident was not the major cause of claimant's current cervical spine condition.

[3] For example, Dr. Milam's stated reason for identifying the May 26, 1998 work injury as the major cause was that claimant did not have objective findings of a disc protrusion and acute symptomatology until after that event. (Ex. 39A). And Dr. Ceballos explained only that claimant "did not have the severity of symptoms he now has prior to the industrial accident." (Ex. 45).

Similarly, although Dr. Ceballos noted that claimant sustained an intervening trauma between his May 18, 1998 and June 11, 1998 treatments, Dr. Ceballos did not note any dramatic change in claimant's condition. On the contrary, Dr. Ceballos' treatment notes indicate that by mid-July 1998 (nearly two months after the May 26, 1998 incident) claimant was feeling "much better" and his trigger points were less sensitive. Dr. Ceballos also noted on August 12, 1998 that claimant had been making progress for a few weeks and then "for no reason at all" his pain returned to the same areas as before.

The fact that neither doctor attempts to reconcile his contemporaneous treatment reports with his subsequent opinion that the May 26, 1998 work incident caused claimant's C5-6 disc protrusion further undermines the persuasiveness of these opinions. Consequently, on this record, we conclude that claimant has failed to prove the compensability of the denied conditions (soft-tissue neck condition, soft-tissue upper back condition, degenerative cervical disc disease and right sided C5-6 disc protrusion) by a preponderance of the evidence.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 10, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

In the Matter of the Compensation of
MARCELINO RUIZ, JR., Claimant
WCB Case Nos. 98-05484 & 98-02009
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the self-insured employer's denial of claimant's left wrist carpal tunnel syndrome condition; and (2) upheld the employer's denial of claimant's left index finger condition. On review, the issue is compensability.

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

Claimant has an accepted 1995 claim for an injury that resulted in a fracture of the left index finger. On review, claimant contends that the "current condition" denial of claimant's left index finger includes the accepted 1995 fracture. Because, according to claimant, there is no medical evidence showing that the fracture is not compensable, the "current condition" denial should be set aside to the extent that it denied the accepted fracture.

We find no support for claimant's contention that the "current condition" denial includes the accepted fracture. Instead, we find the denial limited to the "current condition," which does not include the fracture (a condition that previously resolved), and was denied on the basis that it was not causally related to the accepted 1995 claim. Because we also agree with the ALJ that the "current condition" is not compensable, we also conclude that the denial should not be set aside.

ORDER

The ALJ's order dated March 4, 1999 is affirmed.

In the Matter of the Compensation of
LEONARD R. TERRIBLE, Claimant
WCB Case No. 97-04381
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by the Board *en banc*.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of his occupational disease claim for a stress-related mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was employed as a teacher and administrator by the employer, a Catholic high school, for a total of 18 years. The school is operated by the Archdiocese of Portland. Claimant first worked for the school from 1973 to 1975 as a lay volunteer. He left the school in 1975 and returned in 1981 as a Spanish teacher. In 1984, claimant became the chair of the Foreign Language Department. In 1987, he became the chair of the Humanities Department. Ultimately, he became the Curriculum Coordinator of the school, which required him to work with the faculty. In this position, claimant was a liaison between the faculty and the administration. Claimant was also responsible for establishing a hiring committee to make recommendations to the principal for teaching positions. The principal was not required to accept the committee's recommendations. Only the principal of the school has the authority to hire, fire, or sign employment contracts.

Teachers at the school sign an annual employment agreement. The employment agreement signed by lay teachers at the school includes a clause that provides that a teacher may be discharged, for, among other things: "Committing immoral, indecent, or criminal conduct while on school property or during school time or in other circumstances which might adversely reflect upon the reputation and interests of the school." The employment agreement also provides:

> "The Teacher is called to be a role model and a witness to the Gospel of Christ. By accepting employment in a Catholic School, the Teacher agrees to respect Catholic values and to aid in Christian formation by exemplifying a lifestyle of Christian principles both in school and out of school. The Teacher shall exhibit a lifestyle that is compatible with Catholic moral values and professional conduct consistent with Catholic teaching."

In July 1993, a new principal, Father Lopez, came to the school. Outwardly, Father Lopez had always been complimentary to claimant. In this regard, Father Lopez had assured claimant (who is homosexual) that claimant's private life would remain private and that he was not concerned about it. Father Lopez also told claimant that he was a good single parent.

In the 1994-95 school year, claimant began to have problems with Father Lopez. In 1994, claimant was recommended to become the Dean of Studies at the school. Two faculty members told claimant that Father Lopez was asking about the political ramifications and public relations issues that would arise if claimant was appointed to the position. Claimant was not appointed to the position.

Some of claimant's problems with Father Lopez related to the school's hiring process. Part of claimant's job involved establishing a screening committee to evaluate teacher applicants and make recommendations to the principal. In the 1995-96 school year, the screening committee reviewed applications for an opening for a French teacher. The committee rated the applicants and made their recommendation to Father Lopez. Father Lopez hired an applicant not recommended by the committee.

Also at the beginning of the 1995-96 school year, Father Lopez hired four teachers without going through the screening process. Three of the teachers had difficulties in the classroom with instruction and discipline and claimant was asked to assist them. Claimant was unable to help the teachers improve and Father Lopez decided not to renew the contracts of two of the teachers. Claimant was instructed to document the problems with the teachers to avoid legal problems. Both teachers left prior to the end of the school year. Claimant had to find replacement teachers for the classes with only three weeks left in the school year.

Another teacher hired by Father Lopez as a math teacher had no experience teaching at the high school level. She had problems and decided not to return to the school for the next school year. Before leaving, the teacher gave an exam that a majority of her class failed. This angered Father Lopez who asked that the teacher be contacted to reevaluate the grades. Claimant felt that if the teacher had gone through the screening process, she would not have been recommended for the position because of her lack of experience at that level.

In 1995, Father Lopez decided not to renew the contract of Mr. Markinson, a theology teacher. Because Mr. Markinson had a reputation as being a good teacher, some of the faculty were concerned or upset when he was not retained. Some teachers asked claimant why Markinson's contract was not renewed. Claimant did not know and could not answer. Claimant went to Father Lopez, who would not tell claimant why he decided not to renew the Markinson contract. Later, it became known that Markinson's contract was not renewed for reasons related to his "lifestyle."

Markinson was believed by Father Lopez and some other employees of the school to be cohabiting with another man in a homosexual relationship. Father Lopez believed that Markinson's behavior did not comply with the morals clause of the teacher's contract. One teacher asked claimant why he was still at the school while Markinson was not.

When he was initially approached by teachers who wanted an explanation for Markinson's non-renewal, claimant could not give an explanation because he did not know the reason for the decision. After he learned the reason for the non-renewal of Markinson's contract, claimant began to feel threatened and insecure about his job at the school.

After the Markinson situation, claimant was told by Ms. Moore, the financial administrator of the school, that when claimant had redecorated his office in 1995, Father Lopez remarked to her that claimant's office decor represented a lifestyle that he did not approve. Ms. Moore felt that Father Lopez' comment was homophobic and shared this impression with claimant.

Late in the summer of 1996, the school had to fill a position for a computer teacher. The committee approved an applicant and Father Lopez gave the applicant the impression that she had been hired. The teacher came in the next day to sign a contract with Father Lopez, but the contract was not signed that day. The teacher, who had already informed her current employer that she was resigning, received the impression from Father Lopez that he was possibly reneging on the decision to hire her. Father Lopez left town for a few days and during this period the teacher, who was upset, called claimant once or twice a day to ask what was happening. When Father Lopez returned, he ultimately did sign a contract with the teacher. The incident, however, was stressful for claimant.

In June of 1996, there was a meeting between the faculty and the superintendent of schools for the Archdiocese, Mr. Mizia. Father Lopez was not present. At the meeting, faculty members expressed their concerns about the school and Father Lopez. Mr. Mizia testified that he shared the concerns with Father Lopez without revealing the identity of the persons who raised the concerns. Nevertheless, claimant had a conversation with Father Lopez after the meeting in which Father Lopez indicated that Mr. Mizia had told him that claimant had spoken at the meeting in a way that was philosophically in opposition to the school. Claimant was distressed that the confidentiality of the meeting had been breached. Other teachers were also approached by Father Lopez about statements they had made at the meeting.

In 1986, claimant sought treatment from Dr. Noparstak for stress related to overwork. Claimant filed a workers' compensation claim which was accepted and was off for a medical leave of absence. Claimant next sought treatment from Dr. Noparstak in 1992 for issues related to a work incident, sexual dysfunction and cosmetic surgery.

Claimant next saw Dr. Noparstak in May 1996 for emotional distress related to events at work. Claimant eventually went on medical leave and decided to resign. He filed a workers' compensation claim in February 1997 for mental stress. The employer denied the claim.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the dismissal of Mr. Markinson was the main incident leading to claimant's emotional disorder. The ALJ further concluded that the employer's conduct in dismissing Markinson was protected under the First Amendment of the U.S. Constitution and could not be viewed as a source of compensable emotional distress under Oregon law. Consequently, the ALJ upheld the employer's denial.

Claimant has the burden to prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). Existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d). Additionally, pursuant to ORS 656.802(3)(a)-(d), the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation or reasonable, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. *Id.*

Two medical experts address the nature and cause of claimant's condition. Dr. Glass, a psychiatrist, examined claimant on behalf of the employer. Dr. Glass opined that claimant did not have a diagnosable psychiatric illness. On this basis, Dr. Glass concluded that claimant did not have a psychiatric illness or impairment caused in a major way by his work exposure with the employer.

Dr. Noparstak, also a psychiatrist, has treated claimant in the past for unrelated problems and, since May 1996, has treated claimant for the alleged work-related stress resulting in the workers' compensation claim. Dr. Noparstak diagnosed an adjustment disorder with mixed anxiety and depressed mood and opined that the major contributing cause of claimant's condition and need for treatment was his work exposure.

After considering the medical evidence, we rely on the opinions of Dr. Noparstak. Dr. Noparstak had treated claimant for a long period of time and is more familiar with claimant's history and the non-work-related stressors to which claimant might have been exposed. In addition, Dr. Glass did not examine claimant until well after the allegedly stressful events and only evaluated claimant after he had left work and undergone treatment. Under such circumstances, Dr. Noparstak is in a better position to give an opinion regarding the nature of claimant's condition and its causes. Accordingly, we defer to Dr. Noparstak's opinion. See *Weiland v. SAIF*, 64 Or App 810 (1983) (we generally rely on the opinion of the treating physician absent persuasive reasons to do otherwise). Having found Dr. Noparstak's opinion persuasive, we now turn to the issue of whether the stressors that claimant alleges caused his mental disorder are compensable under ORS 656.802(3)(a)-(d)

It is undisputed that the events cited by claimant exist in a real and objective sense. In addition, based on Dr. Noparstak's opinions, claimant has a mental disorder (adjustment disorder) that is generally recognized in the medical and psychological community. The parties' dispute centers on whether or not the stressors implicated by claimant are generally inherent in every working situation and whether claimant's stress is related to his anticipation of his own cessation of employment or the employer's reasonable disciplinary, corrective or job performance evaluation actions.

We, thus, examine the stressors that claimant and his physician believe caused his illness. When Dr. Noparstak first saw claimant in May 1996, claimant was concerned about Father Lopez' decision not to renew Mr. Markinson's contract because of Markinson's lifestyle. Also mentioned in Dr. Noparstak's chart notes were incidents regarding a comment by Father Lopez about the decor of claimant's office and not being promoted to a job that would require more public contact. In June and July of 1996, Dr. Noparstak's notes indicate that claimant discussed issues related to his son and ex-wife. In August 1996, claimant raised issues relating to the hiring process at work. Specifically, claimant talked about the incident in which the teacher felt that Father Lopez was reneging on a decision to hire her after she had given notice to her previous employer. In addition, claimant raised the meeting with the Archdiocese representative and claimant's concerns over the breach of confidentiality of the meeting. Dr. Noparstak also identified Father Lopez' "capricious" hiring and berating of teachers in front of students as causing claimant stress.

The phrase "generally inherent in every working situation" means those conditions that are common to the full range of working situations. *Whitlock v. Klamath County School Dist.*, 158 Or App 464 (1999). We do not find the events identified by Dr. Noparstak to be conditions generally inherent in the full range of employments. Specifically, an employer's disapproval of one's "lifestyle" is not a condition that is generally inherent in every employment situation. Father Lopez' "homophobic" criticism of claimant's office decor, his handling of the Markinson dismissal, and the decision not to promote claimant to a position with public contact because of his "lifestyle" are all incidents that, according to claimant's testimony and Dr. Noparstak's opinion, caused claimant emotional distress and created a threatening and hostile atmosphere. None of these are conditions that are common to the full range of working conditions.

Likewise, we do not find that Father Lopez' hiring decisions are generally inherent. In this regard, while Father Lopez had the sole authority to hire, no explanation was offered by Father Lopez that justified his decisions not to hire persons recommended by the hiring committee. One would expect a reasonable explanation for not following the committee recommendations that were solicited by the employer. These hiring actions caused claimant stress when the teachers were unable to fulfill their teaching duties. Claimant was placed in the position of handling the effects of the hiring decisions. Moreover, other actions of Father Lopez, such as criticizing teachers in front of their students, also do not appear to be "generally inherent" stressors. In short, we find that Father Lopez' actions were so extreme and arbitrary that they cannot be considered management decisions that are generally inherent in every working situation.[1]

The employer argues that claimant's reactions to the termination or disciplinary, corrective or job performance evaluation action against another employee are conditions generally inherent. Specifically, the employer contends that its actions regarding Mr. Markinson are excluded from consideration as generally inherent. In support of its argument, the employer relies on an ALJ's opinion in another case that was adopted by the Board that held that stress arising from the termination of or reasonable disciplinary action against another employee was a condition that was generally inherent in every working situation under ORS 656.802(3)(b).

Considering that the Board chose not to articulate its own opinion or to publish the adopted opinion, the order is of limited precedential value. In any case, we do not disagree with the ALJ's decision because it acknowledges that, under some circumstances, an employer's termination of, or discipline against, another employee, *might not be "generally inherent."* We agree that while stress caused by the *routine* firing or laying off of other workers in the workplace might be a condition that is "generally inherent" in every working situation, under the particular facts of this case, we do not find that the circumstances and manner of Markinson's dismissal can be considered "generally inherent" in every working situation.

In this regard, the employer's termination of Markinson was but one of several stressors identified by claimant and Dr. Noparstak as causing claimant's mental disorder. In addition, the manner in which the employer dismissed Markinson was so unreasonable that it cannot be considered generally inherent. In this regard, Father Lopez' refusal to tell claimant the reasons for Markinson's dismissal was unreasonable given that part of claimant's job was to be a liaison between the administration and the teachers. It should have been evident to the employer that other teachers would be concerned and approach claimant regarding the dismissal with questions. Regardless of whether the employer's dismissal of Markinson was justified,[2] Father Lopez' handling of the matter was stressful not only to claimant, but also to several other teachers who shared their concerns with claimant.[3]

The employer argues that claimant's stress caused by the anticipation of his own unemployment is not compensable. Generally, a worker's stress attributable to actual or anticipated unemployment is not compensable, but illness resulting from the circumstances and manner of discharge can be regarded as intrinsic to the employment relationship before termination and can lead to compensation. *SAIF v. Weathers*, 151 Or App 510, 517 (1997). In *Bogle v. Department of General Services*, 136 Or App 351 (1995), the court pointed out that "the circumstances or manner of possible layoff or job transfer are events intrinsic to the employment relationship[.]" Unusual stress related to those events, however, may produce a compensable illness. In *Elwood v. SAIF*, 298 Or 429, 433 (1985), the Supreme Court stated that the line runs between illness resulting from the stress of actual or anticipated unemployment, which

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[1] We distinguish Father Lopez' actions from those in cases such as *Patrick W. Real*, 49 Van Natta 2107 (1997). In *Real*, we held that where new management procedures were not excessive or unreasonable, they are considered generally inherent. Here, in contrast, we find that Father Lopez' actions were not generally inherent because they were extreme and there was no apparent mechanism for ensuring Father Lopez' accountability for those actions.

[2] We offer no opinion regarding the propriety of the employer's dismissal of Mr. Markinson. We are able to decide the compensability of claimant's occupational disease claim without delving into the propriety of the employer's decision not to renew Markinson's teaching contract.

[3] It is understandable that claimant would be concerned considering that no "lifestyle" dismissals had occurred during his 18 year career prior to the Markinson dismissal and considering that other employees, including Father Lopez (who had assured claimant that his lifestyle would remain private) knew of claimant's "lifestyle."

is not compensable, and illness resulting from the circumstances and manner of discharge, which can be regarded as events still intrinsic to the employment relationship before termination and can lead to compensation.

Rather than distress related to a fear of unemployment, we are persuaded, based on this record, that any stress that claimant had regarding Markinson's dismissal resulted from the manner and circumstances surrounding the dismissal rather than claimant's fear of his own termination. We find that the handling of Markinson's dismissal, the hostile environment and unreasonable actions of Father Lopez, including not revealing the reason for the Markinson dismissal to claimant, who was the liaison between the administration and the teachers, and not claimant's anticipation of his own termination caused claimant's distress. Thus, we find that claimant's illness was caused by circumstances intrinsic to the employment relationship and not to the anticipation of discharge.

The employer also argues that distress over another employee's termination is also excluded under ORS 656.802(3)(b). We disagree. Based on the text and context of the statute, we find that the statute only excludes distress over the worker's own cessation of employment. The statute does not except distress related to the handling of another's cessation of employment.[4] *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993) (to determine the meaning of statutes, we examine the text in context, turning to legislative history only if we cannot discern the meaning of the statutes from that review). In this regard, the remainder of ORS 656.802(3) plainly refers to conditions that the worker him or herself must experience in order to establish a right to compensation.[5]

The employer further argues that the Board cannot inquire into the "reasonableness" of Father Lopez' decision not to renew the contract of Mr. Markinson because such an action would involve excessive entanglement of the state into a religious decision and would violate the employer's First Amendment rights under the Free Exercise and Establishment Clauses of the federal constitution. We are not statutorily authorized to inquire into the "reasonableness" of Markinson's non-renewal. Instead, our authority is limited to a claim for workers' compensation benefits and the applicable standards thereunder. To determine whether claimant's occupational disease claim is compensable, we need not delve into the constitutionality or propriety of the employer's decision not to renew Markinson's contract.

Claimant argues that the workers' compensation system is a neutral law of general application that does not impose a limitation on the freedom of speech. On this basis, claimant argues that even if the employer's actions result in a compensable claim, that does not equate to a limitation on the employer's Constitutional freedom of speech. Claimant argues that the ALJ's focus on the dismissal of Markinson was incorrect and that the dismissal was not the sole source of claimant's need for treatment. The employer argues that to evaluate claimant's claim, the Board must determine whether the events underlying claimant's claim were based on "reasonable disciplinary corrective or job performance evaluative action."

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[4] We note that the legislative history supports our interpretation. The language in the statute excluding from consideration reasonable disciplinary, corrective or job performance evaluation actions by the employer or cessation of employment was added in 1987 as part of HB 2271. The language was added by the Chair of the Senate Labor Committee to clarify the occupational disease statute. In explaining the additions to the statute, Senator Larry Hill, the Committee Chair stated "This would provide that a mental disorder would not be compensable if it arose out of reasonable disciplinary, reasonable corrective or reasonable job performance evaluation actions by the employer or from cessation of employment. *You can't file a claim because you're fired or you're laid off.* You can't file a claim because your employer reasonably corrected your job performance * * *." (64th Legislative Assembly, Senate Committee on Labor, June 8, 1987, Tape 201, Side A). The legislative history supports a conclusion that the "cessation of employment" language was added to prevent the worker who claimed compensation from being able to establish a compensable mental stress claim from stress caused by his or her own cessation of employment. In addition, the Supreme Court's decision in *Elwood v. SAIF* that held that the occupational disease law did not make illness from losing a job a compensable risk of the job issued in 1985, prior to the 1987 legislative session. *Elwood* involved a claimant whose stress was caused in part by her own termination.

[5] The employer also argues that claimant has not established by clear and convincing evidence that his mental disorder arose out of and in the course of employment. *See* ORS 656.802(3)(d). The persuasive medical evidence does not implicate any non-work-related causes for claimant's mental disorder. Accordingly, we reject the employer's argument and find the evidence satisfies the clear and convincing standard.

First, the Markinson incident was not the only stressor identified as causing claimant's illness. As we noted above, Dr. Noparstak's notes identified several other work-related factors or incidents which contributed to claimant's mental condition, even though the incident involving Markinson's dismissal was identified as an important factor. But we disagree with the employer's assertion that any consideration of the Markinson event would violate the employer's First Amendment rights. In this regard, to determine whether claimant's claim is compensable, it is unnecessary to "examine church doctrine to determine whether it was accurately applied." The circumstances surrounding the employer's handling of Markinson's non-renewal may be relevant to claimant's claim, but we need not interpret the church's doctrine or determine whether or not Markinson should have been terminated. Thus, we do not find that our consideration of the Markinson dismissal as one of several work-related events that contributed to claimant's condition violates the employer's constitutional rights.[6]

In conclusion, based on the aforementioned reasoning, we find that claimant's mental disorder claim satisfies the statutory prerequisites prescribed in ORS 656.802(2) and (3). Accordingly, the claim is compensable and the employer's denial must be set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the voluminous record and claimant's appellate briefs), the complexity of the issue, the nature of the proceedings and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 18, 1998 is reversed. The employer's denial is set aside and the claim remanded to the employer for processing according to law. For services on Board review, claimant's attorney is awarded $6,500, payable by the employer.

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[6] The basis for our reasoning regarding the handling of the Markinson dismissal was not that Father Lopez' reasons for not renewing the contract were wrong. Rather, we find that the handling of the dismissal, especially the failure to explain the decision to claimant given his position as a liaison between the teachers and the administration, was unreasonable. Father Lopez could have simply informed claimant that Markinson was terminated for a violation of a provision of his teacher contract.

Board Member Haynes dissenting.

I would find, based on the following reasoning, that claimant has not met his burden of proof to establish compensability of his mental disorder. Consequently, I respectfully dissent.

As noted by the majority, the phrase "generally inherent in every working situation" means those conditions that are common to the full range of working situations. *Whitlock,* 158 Or App at 475. Dr. Noparstak identified the hiring decisions made by Father Lopez as one of the stressors that contributed to claimant's mental disorder. Specifically, Father Lopez' decisions to hire certain teachers who were not recommended by the hiring committee was a factor identified by claimant and Dr. Noparstak as causing claimant stress.

I believe that Father Lopez' hiring decisions are conditions generally inherent in every employment situation. In this regard, Father Lopez, as the school's principal, had the sole authority to make hiring decisions. Decisions concerning hiring are subjective and although Father Lopez' decisions might have been annoying to the hiring committee members, this type of management decision occurs every day in the broad range of employments. *See Vicki L. Havlik,* 51 Van Natta 98 (1999) (new management policies are conditions generally inherent in all working situations); *Patrick W. Real,* 49 Van Natta 2107 (1997) (new management methods are generally inherent), *aff'd mem* 157 Or App 723 (1998). Here, while the hiring practices were not necessarily "new," they are the type of management decision that occurs daily in all employments. Although some of those hired by Father Lopez may not have been successful, I am not persuaded that the hiring decisions were so unreasonable or ill-advised that they are other than the sort of decision made every day with which employees without hiring authority might disagree.

Because Dr. Noparstak's opinion does not indicate whether the other stressors he identifies excluding Father Lopez' hiring decisions are the major cause of claimant's mental disorder, I would find that claimant has not met his burden of proof. *See Lori 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). For the reasons set forth above, I disagree with the majority's opinion and offer this dissent.[1]

[1] In light of my evaluation of the medical and lay evidence, it is unnecessary for me to address the other portions of the majority's analysis regarding the compensability of claimant's mental disorder claim.

In the Matter of the Compensation of
BEATRICE L. DOWNS, Claimant
WCB Case No. 98-01174
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Hornecker, Cowling, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of her claim for her bilateral foot condition. In its brief, the insurer contends that a copy of claimant's request for review was not timely served on all parties and this matter should be dismissed. On review, the issues are motion to dismiss and compensability. We deny the insurer's motion to dismiss and affirm the ALJ's order.

FINDINGS OF FACT

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

On February 19, 1999, the ALJ issued an Opinion and Order upholding the employer's denial of claimant's bilateral foot condition. On March 19, 1999, the Board's Medford office received claimant's hand-delivered request for review. The attached Certificate of Service provided that a copy of the request for review was mailed to the employer's attorney on March 19, 1999. The employer's attorney received its copy of the request for review on March 23, 1999.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The employer contends that it did not receive claimant's request for review until March 23, 1999, which is more than 30 days after the date of the ALJ's order. Consequently, it moves for dismissal of claimant's request as untimely.

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

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 record contains claimant's attorney's certificate of mailing that was included with claimant's request for review. The certificate of mailing provides that a copy was mailed to the employer's attorney on March 19, 1999. Moreover, this evidence has not been rebutted by the insurer. Accordingly, because timely mailing to a party's attorney, in the absence of prejudice to a party is sufficient, we conclude that we have jurisdiction over this matter. Therefore, the insurer's motion to dismiss is denied.

Compensability

We adopt the ALJ's "Opinion," with the exception of the ALJ's "Conclusion" on page 11 of the Opinion and Order. We substitute the following supplementation.

Claimant argues that the ALJ erred in relying on the opinion of Dr. Schilperoort, orthopedic surgeon. Claimant contends that Dr. Schilperoort did not have an accurate history of claimant's right foot sprain injury. Specifically, claimant argues that Dr. Schilperoort did not understand that the pain in her right foot began as a result of repeated pivoting during her day of substitute work scaling candy on approximately June 8, 1997. Claimant argues that, by the time she was examined by Dr. Schilperoort in March 1998, the right foot sprain that she had sustained in June 1997 had resolved and, accordingly, Dr. Schilperoort focused only on the degenerative conditions. Moreover, claimant contends that Dr. Schilperoort also had an incorrect history with regard to the onset of her left foot pain.

After reviewing the record, we conclude that it is not clear whether any of the doctors who examined claimant had an accurate history with regard to the onset of claimant's right foot pain. Although claimant relies on the opinion of Dr. DeKorte, her treating podiatrist, Dr. DeKorte took a history that, while pivoting on her right foot at work, claimant "felt a sudden pain." (Ex. 4-1). However, at hearing, claimant testified that there was no "sudden sharp pain" that day and her foot "just started aching and it just gradually got worse by the end of the day." (Tr. 20, 21). Consequently, we do not accept claimant's argument that Dr. DeKorte had the most accurate description of an incident in June 1997 involving claimant's right foot.

Finally, we agree with the ALJ's conclusion that Dr. DeKorte's opinion is not persuasive in light of his failure to weigh or discuss the preexisting or idiopathic right and left foot conditions identified by Drs. Schilperoort and Dixon. (Exs. 7, 8, 9). *See Dietz v. Ramuda*, 131 Or App 397 (1994). Consequently, because Dr. DeKorte's opinion is the only expert opinion that would arguably support causation, and because we have found that his opinion is conclusory and therefore, not persuasive, claimant has failed to meet her burden of proof. Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated February 19, 1999 is affirmed.

August 11, 1999 Cite as 51 Van Natta 1382 (1999)

In the Matter of the Compensation of
KENNETH F. PLUMMER, Claimant
WCB Case No. 98-07991
ORDER OF ABATEMENT
Westmoreland & Mundorff, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

The employer requests reconsideration of our July 13, 1999 Order on Review that: (1) found that its failure to appear at the hearing was unjustified and constituted a "waiver of appearance" under OAR 438-006-0071; and (2) denied remand. In order to allow sufficient time to consider the motion, we abate and withdraw our July 13, 1999 order.

Claimant is allowed 14 days from the date of this order in which to respond to the motion. Thereafter, we shall proceed with our reconsideration of this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOAN BEAVER, Claimant
Own Motion No. 99-0112M
OWN MOTION ORDER
Stebbins & Coffey, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable cervical condition and right carpal tunnel syndrome. Claimant's aggravation rights expired on February 20, 1992. The insurer initially 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.

The insurer also denied the compensability of claimant's current condition on which claimant filed a request for hearing with the Hearings Division (WCB Case No. 99-02492). We consolidated the own motion matter with the litigation pending before the Hearings Division.

On July 21, 1999, Administrative Law Judge (ALJ) Black approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. The insurer agreed to rescind its compensability denial and "process the claim, and to pay compensation according to law." In addition, claimant's hearing request was dismissed with prejudice.

Based on the approved Stipulation, the insurer has submitted an amended recommendation in which it agrees that: (1) claimant's current condition is compensable; (2) her surgery is appropriate treatment for her compensable condition; and (3) claimant was in the work force at the time of her disability. Under such circumstances, claimant's current neck condition has been determined to be compensable under her 1985 injury claim. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

On April 15, 1999, claimant underwent an anterior cervical diskectomy and fusion at C4-5. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Here, the insurer initially contended that claimant was not in the work force at the time of her current worsening. Responding to an inquiry from the Board's staff, the insurer now agrees that claimant was in the work force at the time of her current worsening. Under such circumstances, the record establishes that claimant was in the work force at the time of her current worsening which required surgery.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning April 15, 1999, the date she was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
WOODROW J. EVANS, Claimant
WCB Case Nos. 98-05267 & 98-05144
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Twin City Fire Insurance Company (a Hartford company, hereafter "Hartford") requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to dismiss as untimely claimant's hearing request concerning Hartford's "back up" denial of responsibility for claimant's injury claim based on lack of coverage; (2) set aside its "back up" denial of claimant's low back injury; (3) upheld the responsibility denial of Travelers Indemnity Co. (Travelers) for the same condition; and (4) awarded claimant a $1,000 attorney fee under ORS 656.308(2)(d), to be paid by Hartford. In his reply brief, claimant contends that he is entitled to an attorney fee award under ORS 656.386(1). On review, the issues are timeliness of the hearing request, the propriety of Hartford's "back up" denial, responsibility and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked as a pipe fitter for the employer. On or about November 15, 1997, the employer was purchased by another company. On that same date, Travelers became the employer's workers' compensation carrier. Prior to that date, Hartford had been the employer's carrier.

On February 23, 1998, claimant was injured in the course and scope of his employment. The employer submitted the claim to Hartford on March 19, 1998. (Ex. 2). On March 23, 1998, Hartford accepted the claim as a nondisabling thoracic/lumbar strain. (Ex. 9). Two weeks later, on April 8, 1998, Hartford issued a second "Notice of Acceptance," accepting the claim as a "disabling claim for a thoraco lumbar strain." (Ex. 14).

Some time between April 8, 1998 and April 15, 1998, Mr. Nardone, a claims specialist for Hartford, learned that Hartford had ceased to be the guaranty contract insurer of the employer as of November 15, 1997. (Tr. 19-21). Thereafter, on April 15, 1998, Hartford issued a denial "rescinding the April 8, 1998 acceptance" and referring the claim back to the employer to submit the claim to the current carrier. (Ex. 15).

The employer submitted the claim to Travelers on April 22, 1998. (Ex. 1). Although Travelers had coverage at the time of claimant's injury, it denied the claim on the basis that claimant's strains did not arise out of and in the course of employment with the employer.

Claimant timely filed a request for hearing concerning Travelers' denial on June 29, 1998. On July 1, 1998, claimant filed a second request for hearing concerning Hartford's April 15, 1998 "back up" denial.

CONCLUSIONS OF LAW AND OPINION

Finding that Hartford's April 15, 1998 "back up" denial was "invalid," the ALJ determined that claimant's failure to file a request for hearing regarding that denial within the 60 day time period of ORS 656.319(1)[1] was excused under *Knapp v. Weyerhaeuser Co.*, 93 Or App 670 (1988). In addition, relying on *Jose S. Sandoval-Perez*, 48 Van Natta 395 (1996), the ALJ further found that, although Travelers

[1] This section provides as follows:

"(1) With respect to objection by a claimant to a denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the mailing of the denial to the claimant; or

"(b) The request is filed not later than the 180th day after mailing of the denial and the claimant establishes at hearing that there was good cause for failure to file the request by the 60th day after mailing of the denial."

was the carrier on the risk at the time of claimant's injury, Hartford remained responsible for the claim because it accepted the claim when it knew or should have known that it was not providing coverage at the time of claimant's injury.

On review, Hartford contends that *Knapp* is inapplicable and that, in order to litigate the merits of its "back up" denial, claimant was required to request a hearing within 60 days (or show good cause for his failure to do so). Hartford further argues that, because claimant did not timely request a hearing or show good cause under ORS 656.319(1)(b), its denial should be reinstated and that Travelers should be responsible for claimant's injury. As set forth below, we agree with Hartford.

In *Knapp*, the court held that, where there is no legal basis for a carrier's denial, *i.e.*, where the denial is a "nullity," a claimant is not subject to the limitations period of ORS 656.319(1)(a). 93 Or App at 674. There, the employer had issued a "back up" denial of the claimant's occupational disease claim after a previous denial had been set aside by litigation order. The employer based its "back up" denial on information obtained subsequent to the prior litigation.[2] The court held that the doctrine of issue preclusion was applicable and that the employer was not permitted to collaterally challenge a final Board order on the grounds of fraud or misrepresentation. The court then concluded that, because the employer's denial "had no basis in law," the claimant's request for hearing was not subject to dismissal on the ground that it was not filed within 60 days. *Id.*

We have subsequently distinguished *Knapp* from the situation where the carrier's "back up" denial was not "invalid as a matter of law." In *Wayne A. Moltrum*, 47 Van Natta 955 (1995), we held that where the carrier was permitted to issue a "back up" denial under ORS 656.262(6), the claimant must timely request a hearingmp to contest the denial. In *Moltrum*, the Department referred the claimant's claim to the SAIF Corporation after determining that the claimant's purported emloyer was noncomplying. SAIF accepted the claim on the noncomplying employer's behalf but later learned that another employer was responsible for providing coverage. SAIF then denied the claim on that basis. The claimant's request for hearing was filed more than 60 days, but less than 180 days after receipt of SAIF's denial. We rejected the claimant's contention that his request for hearing was unnecessary because SAIF's "back up" denial was invalid. Instead, we held that under *former* ORS 656.262(6), SAIF could issue a "back up" denial based on lack of coverage even though it had not been appointed a paying agent under ORS 656.307. We further found that, in order to contest the merits of SAIF's "back up" denial, the claimant had to timely request a hearing or show good cause for his failure to do so. *Id.* at 957.

Here, as in *Moltrum*, we decline to find Hartford's April 15, 1998 "back up" denial "invalid as a matter of law." Indeed, in *SAIF v. Shaffer*, 129 Or App 289 (1994), the court specifically held that ORS 656.262(6) permits a carrier to issue a "back up" denial for lack of coverage provided that the denial is issued within two years of the claim acceptance. *See also Jose S. Sandoval-Perez*, 48 Van Natta at 396 ("ORS 656.262(6) allows 'back up' denials based on lack of coverage, provided that the claimant's compensation is not at risk and the dispute is limited to which carrier is responsible for payment of benefits."). In other words, because ORS 656.262(6)(a) allows Hartford to issue a "back up" denial for lack of coverage within two years and permits a claimant to timely request a hearing regarding the denial to determine whether the denial was based on "later obtained evidence," the denial is not invalid as a matter of law (even if it would otherwise be inappropriate on the merits).[3] Consequently, in order to contest the April 15, 1998 denial, claimant had to timely request a hearing.[4]

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[2] Based on later obtained evidence, the employer in *Knapp* believed that the claimant had testified untruthfully at the prior hearing.

[3] In *Wayne A. Moltrum*, 47 Van Natta at 957 n2, we noted that the merits of the "back up" denial can only be determined if the claimant's request for hearing is found to be timely. And, in *Sandoval-Perez*, 48 Van Natta at 396, we recognized that although ORS 656.262(6) allows "back up" denials based on lack of coverage, it is a factual determination whether the denial was properly based on later obtained evidence. There, the claimant had timely requested a hearing on the carrier's "back up" denial. The evidence presented a hearing established that the carrier had, in its possession, an insurance contract setting forth the coverage period for the employer when it mistakenly accepted the claimant's claim. Based on this evidence, we found that the carrier's local office knew or should have known that it was not providing coverage when the claimant filed his claim. We concluded that the carrier's subsequent discovery that it did not provide coverage on the day that the claimant was injured did not constitute "later obtained evidence" sufficient to support its "back up" denial of responsibility. *Id.*

[4] Because claimant did not offer any evidence or argument on the good cause issue, we need not address whether we have jurisdiction under ORS 656.319(1)(b).

Furthermore, although Hartford sought to clarify and/or amend its denial at hearing (to correct a typographical error and specifically reference the March 24, 1998 acceptance in addition to the April 8, 1998 acceptance), these revisions do not revive or extend claimant's time to request a hearing on the "back up" denial of the previously accepted claim. As explained below, under the circumstances of this case, the date of the "acceptance" is irrelevant. Therefore, this clarification of, or amendment to, the "back up" denial is immaterial.

Hartford's March 24, 1998 letter advised claimant that his claim for a February 23, 1998 thoracic/lumbar strain had been accepted as a nondisabling injury. The letter also advised claimant of his right to challenge the classification of his claim. The April 8, 1998 acceptance notice, which referenced the same claim number and date of injury, advised claimant that Hartford had accepted the claim as disabling. Thus, the April 1998 notice was not a new acceptance but rather a reclassification of the previously accepted claim.[5] In other words, although Hartford sent two notices of acceptance, there was only one claim (for the February 23, 1998 injury), one acceptance (of a thoracolumbar strain), and one reclassification (from nondisabling to disabling).

Under these circumstances, Hartford's April 15, 1998 "back up" denial (which specifically referred to the April 8, 1998 acceptance) was sufficient to notify claimant that the acceptance of his claim (as identified by the claim number and the February 23, 1998 date of injury) had been withdrawn, that the claim was being denied for lack of coverage and that, if he objected to this denial, he had 60 days to file a hearing request. Because claimant did not timely request a hearing challenging Hartford's "back up" denial, the denial must stand. *See Wayne A. Moltrum*, 47 Van Natta at 957-58.

At hearing, all of the parties agreed that claimant was injured in the course and scope of employment on February 23, 1998, that medical causation was not at issue and that Travelers provided coverage at the time of hearing.[6] (Tr. 7-13). Travelers' only defense to responsibility for the claim was that Hartford's "back up" denial was improper under ORS 656.262(6) and *Jose S. Sandoval-Perez*, 48 Van Natta at 395. (Tr. 7). But, in light of our determination that claimant had to timely request a hearing in order to contest Hartford's denial and that the denial has become final by virtue of claimant's failure to do so, the merits of the denial are not now subject to litigation. Under these particular circumstances, Travelers is responsible for claimant's claim.

Finally, claimant contends that, in addition to the $1,000 awarded by the ALJ pursuant to ORS 656.308(2)(d), he is also entitled to an attorney fee under ORS 656.386(1) for his services at hearing because that Hartford continued to dispute compensability by challenging the timeliness of his request for hearing. We disagree. Because we have found that Hartford's denial must be reinstated (based on claimant's failure to timely request a hearing), claimant has not prevailed over the denial. Therefore, claimant is not entitled to a fee under ORS 656.386(1).

ORDER

The ALJ's order dated April 2, 1999 is reversed. Hartford's "back up" denial is reinstated. Claimant's hearing request on Hartford's denial is dismissed. Travelers' responsibility denial is set aside and the claim is remanded to Travelers for further processing in accordance with the law. Travelers, rather than Hartford, is responsible for the ALJ's $1,000 attorney fee award.

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[5] *See* ORS 656.277, which requires a carrier to report disabling claims to the Director of the Department of Consumer and Business Services. Unlike Hartford's March 24, 1998 acceptance of a nondisabling injury, the April 8, 1998 acceptance of a disabling injury was copied to the Director via the Workers' Compensation Division.

[6] Despite its initial denial on course and scope grounds, Travelers conceded the compensability of claimant's claim at hearing. (Tr. 7).

In the Matter of the Compensation of
SHIRLEY M. MERCER, Claimant
Own Motion No. 98-0320M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's April 19, 1999 Notice of Closure, which closed her claim with an award of temporary disability compensation from June 30, 1998 through September 20, 1998. The insurer declared claimant medically stationary as of December 2, 1998.

In her request for review, claimant contends that she has been in pain since her surgery and that her attending physician has recommended certain exercises to "strengthen my arm. It is coming along slowly." We interpret such a statement as a contention that claimant was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the April 19, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a June 22, 1999 letter, we requested that the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on June 24, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often, is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant requested review because her physician has recommended further treatment in the form of strengthening exercises. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

Claimant contends that she has continued pain and needs additional medical treatment to strengthen her arm. Claimant relies on these contentions to support her position that she was not medically stationary at the time of claim closure. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

The insurer submitted December 2, 1998 and May 19, 1999 letters from Dr. Vigeland, claimant's attending physician, in support of its contention that claimant was medically stationary at the time it closed her claim. In his December 2, 1998 letter, Dr. Vigeland opined that claimant was medically stationary and that "closure was appropriate." In May 1999, Dr. Vigeland recommended some strengthening exercises and advised claimant to return on an as-needed basis. Although recommending additional exercises, Dr. Vigeland neither indicates that claimant's condition is no longer medically stationary nor that this ongoing medical care will materially improve claimant's compensable condition. These opinions are unrebutted.

Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed.[1] Therefore, we conclude that the insurer's closure was proper.[2]

Accordingly, we affirm the insurer's April 19, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we again emphasize that the need for continuing medical treatment to address fluctuating symptoms does not establish that claimant's condition is not medically stationary. *Maarefi*, 69 Or App at 531.

[2] 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
MARK E. LANDON, Claimant
WCB Case No. 98-02810
SECOND ORDER OF DISMISSAL
Bryant, Emerson, et al, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

Claimant requests reconsideration of our July 12, 1999 Order of Dismissal that dismissed claimant's request for review of Administrative Law Judge (ALJ) Marshall's order that upheld the self-insured employer's denial of claimant's left leg injury claim. The employer has submitted a response opposing claimant's motion.

In dismissing claimant's request for review, we found that it was not timely filed because the final day to perfect a timely appeal was Monday, June 14, 1999 and we received the request on June 21, 1999. Claimant accompanies his request for reconsideration of this decision with an affidavit completed by his attorney. In that affidavit, counsel explains that he personally "finalized the request for Board Review, made all the copies and prepared the envelopes for all the necessary parties." According to the affidavit, claimant's attorney then placed the correspondence "in the out going mail basket to be postmarked at a time that I was sure was before our staff person takes the mail over to the" post office.

As we explained in the dismissal order, because the request for review was not mailed by registered or certified mail and we received it after the expiration of the 30-day appeal period, we presume the request was not timely filed unless claimant can show to the contrary. "Filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a).

We find the information in the affidavit insufficient to show that the request for review was "filed," or mailed, on June 14, 1999. Counsel can only attest to having put the request in his office's "out going mail basket," which we find does not show that the thing was *mailed* on that date. That is, claimant's attorney does not demonstrate that he or anyone else actually mailed the request for review on June 14. *Compare Randolph King*, 51 Van Natta 82 (1999) (presumption of untimely mailing rebutted by an affidavit from the claimant's counsel's legal assistant attesting that she timely mailed the request for hearing to the Board and parties). Thus, we continue to conclude that the request for review was not timely filed and we lack jurisdiction to consider the matter.[1]

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[1] Counsel's affidavit also discusses his office's use of a "Pitney Bowes" mail meter and the possibility that the postage meter was not accurately set on June 14, explaining why the envelope containing the request for review was postmarked June 16, 1999. In continuing to decide that the request for review was not timely filed, we rely on the lack of evidence showing that the request was mailed to the Board on June 14 rather than the postmark date on the envelope.

Accordingly, we withdraw our July 12, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our July 12, 1999 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

August 11, 1999 Cite as 51 Van Natta 1389 (1999)

In the Matter of the Compensation of
TYLER LARSON, Claimant
WCB Case No. C991782
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Biehl and Bock.

On July 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.

On July 27, 1999, we wrote the parties requesting an addendum to the CDA, clarifying the amount of consideration. In our letter, we noted that the first page of the agreement provided $3,000 to claimant and $750 to claimant's attorney, which equals a total consideration of *$3,750*. However, the body of the document provided a total consideration of *$3,000* out of which claimant's attorney would receive $750.

We have received the parties' addendum, which provides that the first page should be amended to provide a total due claimant of $2,275. This amount, plus an attorney fee of $750 would equal a total consideration of *$3,025*.

Upon review of the amended CDA, we find that the parties' intent is for a total consideration of $3,000. The disposition proceeds are to be distributed as follows:

$2,275 Total Due Claimant
$ 725 Total Due 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 $750, 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
CLARENCE E. CROSS, Claimant
WCB Case No. 99-00521
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the employer's partial denial of his current right shoulder 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 ALJ's Conclusions of Law and Opinion, with the following supplementation.

On review, claimant contends that the opinion of Dr. Gritzka, an orthopedic surgeon with whom claimant consulted on one occasion, is the most persuasive opinion regarding causation. Claimant argues that the ALJ erred in relying on the opinion of his treating surgeon, Dr. Davidson.

Dr. Gritzka disagreed with the opinions of Drs. Davidson, Farris and Strum, who believed that claimant's current condition was due, in major part, to a preexisting degenerative condition rather than to the compensable injury. During surgery, Dr. Davidson found what he described to be a "degenerative acromioclavicular joint" and a "degenerative rotator cuff tear that was partial." (Ex. 44-5). Dr. Davidson also testified that claimant's impingement syndrome was a "chronic problem" and did not result from the injury. (Ex. 44-11).

Dr. Gritzka agreed that claimant had degenerative arthritis, but believed that the work injury was the major cause of the combined condition and need for treatment. Dr. Gritzka relied on claimant's symptoms following the injury as evidence that the rotator cuff tear was due to the injury, rather than a preexisting condition. (Ex. 46-12). However, Drs. Farris and Strum reported that claimant's preexisting personality disorder which tended to "focus on and embellish physical symptoms" may well be the major contributing cause of claimant's current condition. (Ex. 30-6). Dr. Davidson also reported that, even if claimant had a rotator cuff tear, it would not "explain many of his bizarre complaints...". (Ex. 34-1). Dr. Davidson also agreed that, due to claimant's invalid examination findings, he could not state that claimant had permanent impairment due to the industrial injury. (Ex. 39-2).

Because Dr. Gritzka has not considered or discussed the comments from Drs. Farris and Strum and from Dr. Davidson regarding the contribution of a personality disorder or the invalid findings noted on examination, we do not find it persuasive. Accordingly, we agree with the ALJ's conclusion that the most persuasive opinion has been provided by Dr. Davidson, who was claimant's treating doctor and surgeon. Therefore, the ALJ's order is affirmed.

ORDER

The ALJ's order dated April 26, 1999 is affirmed.

In the Matter of the Compensation of
GERALD W. HANNAH, Claimant
WCB Case No. 94-0699M
OWN MOTION ORDER DENYING RECONSIDERATION
Liberty Northwest Ins. Corp., Insurance Carrier

By letter dated June 11, 1999, claimant, *pro se*,[1] contends that he is entitled to temporary disability benefits related to his compensable left elbow condition. We treat this letter as a request for reconsideration of our prior orders that denied claimant's request for own motion relief.

FINDINGS OF FACT

This case has a long history, but the essential facts can be summarized as follows. Claimant has an accepted left elbow claim with Liberty Northwest Insurance Corporation (Liberty). The claim's date of injury is May 11, 1989. This claim was first closed on August 8, 1989, and claimant's aggravation rights expired five years later, on August 8, 1994.

Beginning in April 1991, claimant underwent several periods of incarceration and parole. During one of these parole periods, claimant worked for Willamette Industries from September 1994 to December 1994, at which time he was terminated. As a result of a conviction in April 1995, claimant is presently serving a 20-year sentence in a federal prison in Missouri.

By letter dated January 4, 1995, Liberty denied claimant's claim for treatment of his then-current left elbow condition. Claimant's claim for temporary disability benefits was referred to the Board in its own motion jurisdiction, along with Liberty's recommendation to deny reopening the claim. By order dated January 10, 1995, as corrected January 19, 1995, the Board denied claimant's request for own motion relief on the ground that claimant's left elbow condition did not require surgery or hospitalization.

Claimant requested a hearing on Liberty's January 4, 1995 denial of claimant's current left elbow condition, raising the issues of compensability and responsibility. (WCB Case Nos. 95-02771 and 95-02772). In addition, claimant requested reconsideration of the Board's January 1995 orders regarding the own motion matter. Because issues relating to compensability and responsibility could affect the own motion matter, the Board withdrew its prior own motion orders on March 31, 1995, referred the matter for a consolidated hearing, and deferred its decision regarding the own motion matter pending resolution of the litigation at hearing. The Administrative Law Judge (ALJ) assigned to hear the compensability and responsibility issues was requested to take evidence on the following issues if the own motion carrier (Liberty) was found responsible for claimant's then-current left elbow condition: (1) whether claimant's compensable condition worsened requiring surgery or hospitalization; and (2) whether claimant was in the work force at the time his condition worsened.

A hearing was held on September 22, 1998, during which claimant was represented by counsel and testified by telephone. Following that hearing, the ALJ issued an October 21, 1998 order that set aside Liberty's January 4, 1995 partial denial and remanded the claim to Liberty for acceptance and processing according to law. That same date, the ALJ submitted an Own Motion Recommendation, concluding that: (1) there was no persuasive evidence to establish that claimant's accepted left elbow condition required surgery or hospitalization; and (2) even if claimant's condition had worsened requiring surgery or hospitalization, he would not be entitled to temporary disability compensation because of his incarceration.

By order dated December 14, 1998, the Board in its own motion jurisdiction determined that, because claimant failed to establish that his compensable left elbow condition worsened requiring surgery or hospitalization, it was without authority to grant claimant's request to reopen his claim for own motion relief. The Board noted that, given claimant's failure to establish the surgery/hospitalization element, it was not necessary to address the work force issue.

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[1] Although represented at the September 22, 1998 hearing, claimant is apparently not represented at this time.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that our Own Motion Order on Reconsideration was mailed on December 14, 1998 and instructed the parties that any request for reconsideration of that order must be filed with the Board within 30 days after the mailing date. Obviously, claimant's June 11, 1999 letter requesting review was filed more than 30 days after the mailing date of our last order regarding this matter. Thus, claimant's request is clearly untimely. The rules relating to our own motion jurisdiction provide that "in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." OAR 438-012-0065. We do not find that claimant's untimely request presents "extraordinary circumstances" justifying reconsideration of our prior order. Therefore, we deny reconsideration. In any event, as explained below, even if we grant reconsideration, the result would not change.

Because claimant's aggravation rights have expired on his left elbow condition claim with Liberty, that claim is within the sole jurisdiction of the Board in its own motion authority. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Furthermore, the legislature has provided strict limitations on the Board's own motion authority. Pursuant to ORS 656.278(1)(a),[2] where a compensable injury worsens requiring surgery or hospitalization, "the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery[.]" Thus, by statute, a worker is not entitled to temporary disability compensation until his or her compensable condition has worsened requiring surgery or hospitalization and he or she actually undergoes the surgery or hospitalization.

Claimant contends that "[i]f Willamette Industries would not have fired me I believe surgery would have been inevitable." But, claimant presents no medical evidence to support his contention that he would have required surgery had he not been fired. In any event, the fact remains that claimant did not require surgery or hospitalization. Therefore, the record does not establish the necessary prerequisite to have claimant's own motion claim reopened for temporary disability benefits, *i.e.*, claimant's compensable condition has not required surgery or hospitalization. For that reason, we are not authorized to reopen claimant's claim for payment of temporary disability benefits.[3]

Claimant makes several arguments regarding the work force issue. In light of our "surgery" decision, however, it is unnecessary to address claimant's "work force" contentions. In other words, even if we agreed with claimant's "work force" arguments, he would not be entitled to benefits because of our "surgery" decision.

Accordingly, we deny the request for own motion relief.

IT IS SO ORDERED.

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[2] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]

[3] Claimant also argues that his "due process rights" were violated because, after his testimony at the hearing via telephone, the telephone connection was disconnected and he did not get to hear the closing arguments.

Claimant does not explain how his failure to hear the closing arguments violated his "due process rights." More particularly, we fail to see how this disconnection would have impacted the lack of medical evidence supporting a need for surgery or hospitalization. In any event, claimant was represented by counsel at hearing and there is no allegation that claimant's counsel was unable to fully participate in the closing arguments and represent claimant's interests. *See Roderick A. Mespelt*, 42 Van Natta 531 (1990) (no violation of due process where, with the consent of the claimant's counsel on the claimant's behalf, an ALJ who had not conducted the hearing decided the case on a transcript of the hearing and closing argument).

In the Matter of the Compensation of
LINDA M. HANSEN, Claimant
WCB Case Nos. 97-00247 & 96-09661
ORDER OF ABATEMENT
Kryger, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of a portion of our July 14, 1999 order that he asserts upheld the SAIF Corporation's current condition denials in their entirety. Claimant asserts that we were mistaken in finding that her then-current cervical strain and/or bilateral carpal tunnel syndrome were no longer being caused in major part by the original compensable claim.

On pages 8 and 9 of our July 14, 1999 order, we summarized our holding as follows:

> "On review, we affirm the ALJ's decision to uphold SAIF's January 6, 1997 denial. We also affirm the ALJ's decision to set aside SAIF's July 24, 1998 partial denial of claimant's bilateral brachial plexus compression/thoracic outlet syndrome. (Ex. 42). We uphold SAIF's September 25, 1996 and January 15, 1997 denials to the extent that they denied claimant's aggravation claim. (Exs. 35, 39). *On the other hand, we set aside SAIF's September 25, 1996 and January 15, 1997 denials to the extent they denied compensability of claimant's current condition.*" (Emphasis supplied).

The "Order" section of our July 14, 1999 order reversed only that portion of the ALJ's order that set aside SAIF's September 25, 1996 and January 15, 1997 denials of claimant's *aggravation* claim.

On review, claimant argued that her "current condition, including the currently diagnosed brachial plexis, thoracic outlet syndrome" is compensable under several theories. (Claimant's br. at 2). Claimant contended that this case "simply boils down to a philosophical medical argument in favor of thoracic outlet syndrome as the appropriate diagnosis as opposed to the philosophy that the condition doesn't exist and even if it does, claimant doesn't have it." (*Id.* at 6). Claimant urged that the "final analysis is that [her] current condition which includes thoracic outlet syndrome/brachial plexus compression is compensable[.]" (*Id.* at 7). Claimant relied on Dr. Konowalchuk's opinion to satisfy her burden of proof and she asserted that he was the only physician to diagnose thoracic outlet syndrome/brachial plexus compression. (*Id.* at 2, 5).

In its reply brief, SAIF understood claimant to be relying on the "existence and potential compensability of alleged brachial plexus compression/thoracic outlet syndrome condition as the basis for setting aside the denials." (SAIF's reply br. at 1). SAIF argued on review that "claimant's case rises and falls depending upon the compensability of the brachial plexus compression/thoracic outlet syndrome condition." (*Id.*)

Our understanding of claimant's argument on review was the same as SAIF's, *i.e.*, that claimant was relying on the compensability of the brachial plexus compression/thoracic outlet syndrome condition as the basis for setting aside SAIF's denials. On reconsideration, claimant is apparently asserting that she has a current cervical strain and/or bilateral carpal tunnel syndrome that requires a determination of compensability.

In order to further consider this matter, we withdraw our July 14, 1999 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Claimant's reply must be filed within 14 days from the date of mailing of SAIF's response. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
HUGH J. O'DONNELL, Claimant
WCB Case No. 98-04771
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for a right inguinal hernia; and (2) awarded an assessed fee of $3,500 for claimant's attorney's services in prevailing over that denial. 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

As the ALJ found, this is an occupational disease claim, which requires claimant to prove that employment conditions were the major contributing cause of his inguinal hernia condition. ORS 656.802. Assessment of major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Moreover, although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Id.* at 401.

Claimant alleges that he first experienced problems in late 1996 or early 1997 while operating the pan washing machine at work. He did not report the incident, sought no medical treatment, and missed no time from work, although subsequently he occasionally had abdominal pain related to lifting. In August 1997, claimant changed job duties and was required to lift garbage sacks weighing over 60 pounds up to 20 times a day. He began to feel a pulling sensation in his groin when he performed lifting activities. Within a few days, he noticed a bulge in his groin. Claimant first sought medical treatment on January 20, 1998. Claimant also engaged in off work lifting activities, which involved carrying a sign approximately three hours per day, four days per week. This sign was about two feet by three feet and was mounted on a staff approximately five feet long. When carrying the sign, claimant usually used a belt with a cup that supported the end of the sign's handle.

Given the nature of the hernia condition, the length of time before claimant sought medical attention, and the off-work lifting activities, the medical causation issue in this case is complex, requiring expert medical evidence for its resolution. *Uris v. Compensation Dept.*, 247 Or 420, 427 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

Only claimant's two treating physicians, Drs. Thoming and Ragsdale, provide any causation opinion.[1] (Ex. 10A, 11). Both opinions are conversation summaries. Dr. Thoming stated that he did not know the cause of claimant's inguinal hernia and that he had no opinion. (Ex. 10A-2). He also

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[1] In making their arguments, the parties focus on which physician should be considered claimant's attending physician. The dissent observes that the employer's sole argument on review regarding the compensability issue is that Dr. Thoming is his attending physician and, as such, his opinion (which does not support compensability) should be determinative. In making this observation, the dissent appears to contend that we are strictly limited to the parties' arguments and need not independently examine the legal theories or the evidence itself. We disagree.

The Board has *de novo* review, which includes determining which law applies to the facts of a particular case, including identifying any applicable administrative rules. The Board applies the law as the record/evidence leads it. *See Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Hewlett-Packard Co. v. Renalds*, 132 Or App 288 (1995)); *Dibrito v. SAIF*, 319 Or 244, 248 (1994) (it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim). In addition, our *de novo* review also requires us to determine the *persuasiveness* of the evidence. While the parties' arguments may help in our review, those arguments are not controlling and cannot require us to go where the law and evidence do not lead. Furthermore, as explained below, here, the evidence does not lead to a compensable claim, no matter which doctor is considered to be claimant's attending physician.

stated that, given the natural history of inguinal hernias in men, there was a chance that claimant was predisposed to developing a hernia. (*Id.*). He noted that activities of daily living and any laborious tasks will exacerbate even mild hernias. (*Id.*). Finally, he stated that hernias are progressive and will not heal themselves. Thus, Thoming's opinion does not support claimant's claim.

The record contains two documents from Dr. Ragsdale. The first document is a January 20, 1998 "First Medical Report" form, on which claimant provided the following description: "Noticed bulge before Oct. 1997, but got painful @ 10/97. r groin." (Ex. 4). In this report, Ragsdale briefly described claimant's symptoms and objective findings, and diagnosed a "right inguinal hernia." (*Id.*). The second document is a conversation summary provided by claimant's attorney. (Ex. 11). That document contains four statements to which Ragsdale agreed based on a standard of reasonable medical probability. First, Ragsdale agreed that he is the surgeon to whom claimant was referred for his right inguinal hernia condition, and he is experienced in diagnosing and treating such conditions. Second, he agreed that he examined claimant on January 20, 1998, found him to have a large right inguinal hernia, and recommended surgery. Third, he agreed that the history claimant gave him:

> "was of pulling a muscle in his right groin lifting on the job approximately two years previously, of developing a bulge in his right groin approximately six months before [Ragsdale] saw him with repeated lifting of heavy objects like garbage bags on the job, and of developing increased pain with such lifting in October 1997 which finally led him to seed medical attention on January 20, 1998." (Ex. 11-2).

Fourth, he agreed that in his "medical opinion, [claimant's] work activities as described above, were the major contributing cause of his right inguinal hernia and of his need for medical treatment." (Ex. 11-2-3). This last statement is Ragsdale's sole causation opinion. Although this opinion includes "magic words," such as "the major contributing cause," it is conclusory, without significant explanation.

The court has explained that a medical opinion must be evaluated in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516 (1999); *Worldmark the Club v. Travis*, 161 Or App 644 (1999). In *Strubel*, the court rejected SAIF's argument that a medical opinion did not meet the *Dietz* standard because it simply related the claimant's symptoms to a work incident instead of his preexisting degenerative disc disease because the claimant had been asymptomatic for ten years before the work incident. The court found that the medical opinion satisfied the *Dietz* standard given the context of the opinion and the record as a whole. There, in response to an inquiry from the claimant's attorney, the doctor provided a history of his treatment of the claimant, stated that he was aware of the claimant's 1987 injury and was aware that 1997 x-rays revealed some disc degeneration. He then stated that, given his understanding of the claimant's condition over the last ten years, including the fact that the claimant had been completely asymptomatic, he believed that the claimant's work injury was the most likely major contributing cause of the claimant's symptoms. Given the context of the doctor's opinion, the court agreed with the Board that it met claimant's burden of proof.

In *Travis*, the court applied *Strubel* in rejecting a similar argument that the claimant failed to meet the *Dietz* standard. The court determined that the context of the doctors' opinions satisfied the claimant's burden of proof. Specifically, the court determined that the questions asked a physician provided the necessary framework to find that the doctor's responses to those questions established that the work injury was not only the precipitating cause but was also the primary cause of the disputed combined condition. The court also determined that the Board reasonably interpreted a second doctor's opinion, when reviewed as a whole, as supporting the claimant's claim.

Strubel and *Travis* do not help claimant because, here, there is no context within which to evaluate Dr. Ragsdale's opinion. Ragsdale's first report provides very little information. His second report simply recites claimant's history regarding his work activities and the course of his hernia condition and then states that claimant's work is the major contributing cause of his hernia condition. There is no indication that Ragsdale considered or even knew about claimant's off work lifting activities. While claimant testified that these off work activities did not cause problems, the issue before us is medically complex; therefore, claimant's testimony alone is not sufficient. In addition, Dr. Ragsdale did not address Dr. Thoming's concern about claimant's possible predisposition to develop a hernia. We acknowledge that, in order to be legally sufficient and persuasive, medical opinions must be stated in

terms of probability rather than possibility. *Gormley v. SAIF*, 52 Or App 1055 (1981). Nevertheless, Dr. Thoming explained that, at least part of the reason he was unable to offer an opinion as to the cause of claimant's hernia was the possibility that claimant was predisposed to developing a hernia. Given that, it is important that Dr. Ragsdale provide some reasoning for his opinion. Thus, the context of Ragsdale's opinion does not cure the conclusory nature of that opinion.

Thus, based on this record, we find that claimant failed to meet his burden of proving a compensable occupational disease claim and uphold the employer's denial.

ORDER

The ALJ's order dated February 12, 1999 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is revised.

Board Member Phillips Polich dissenting.

I find that the ALJ correctly relied on Dr. Ragsdale's opinion to establish compensability of the right inguinal hernia condition. Therefore, I would affirm and adopt the ALJ's order. Because the majority does otherwise, I respectfully dissent.

The employer's sole argument on review is that the ALJ erred in failing to find that Dr. Thoming, M.D., is claimant's attending physician and in failing to rely on his opinion (which does not support compensability) based on that attending physician status. Neither Dr. Thoming nor Dr. Ragsdale, M.D., submitted any documentation regarding their "attending physician" status. In asserting that Dr. Thoming is claimant's "attending physician," the employer appears to rely on the fact that he was the first physician to examine claimant. I disagree.

Dr. Thoming is the emergency room physician who examined claimant on January 20, 1998, when he first sought treatment for his hernia condition. (Exs. 1, 2). Dr. Thoming saw claimant only that one time and referred him to Dr. Ragsdale, who is a surgeon. Based on the ALJ's reasoning, I would find that Dr. Ragsdale is claimant's attending physician. More importantly, contrary to the employer's argument, the ALJ did not rely on Dr. Ragsdale's opinion solely based on his status as claimant's attending physician. The ALJ also found that Dr. Ragsdale had a more accurate history of the onset of claimant's problems. I agree with that finding. In addition, Dr. Ragsdale had an accurate history of claimant's work activities. (Ex. 11-2).

The majority appears to find that Dr. Ragsdale's failure to discuss claimant's off-work activities involving limited sign-carrying activity makes his opinion less persuasive. I disagree.

The ALJ explicitly and repeatedly found claimant credible based on his demeanor and conduct during the hearing. Furthermore, claimant credibly testified that the sign-carrying activity did not bother him or affect his hernia condition. Although not statutorily required, the Board generally defers to the ALJ's determination of credibility when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). Since the ALJ's credibility finding was based in part on the observation of claimant's demeanor, I would defer to that determination. *See International Paper Co. v. McElroy*, 101 Or App 61 (1990). Thus, claimant's testimony establishes that the sign-carrying activity had no effect on his hernia condition. Therefore, it follows that Dr. Ragsdale's failure to discuss that activity does not affect the persuasiveness of his opinion.

For these reasons, in addition to those addressed by the ALJ, I would find that Dr. Ragsdale's opinion as a whole meets claimant's burden of proving a compensable occupational disease claim. In addition, I would affirm the ALJ's $3,500 assessed attorney fee award. *SAIF v. Bacon*, 160 Or App 596 (1999); *Daryl L. Underwood*, 50 Van Natta 2330 (1998) (citing *McCarthy v. Oregon Freeze Dry*, 327 Or 84, *adhered to on recon*, 327 Or 185 (1998)).

In the Matter of the Compensation of
TERRY J. RASMUSSEN, Claimant
WCB Case Nos. 98-02658 & 98-00670
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Claimant requests reconsideration of our July 16, 1999 Order on Review that reversed the Administrative Law Judge's (ALJ's) order that: (1) set aside Kemper Insurance Company's denial of compensability and responsibility for claimant's left knee condition; (2) upheld the SAIF Corporation's responsibility denial of the same condition. Our order also found Kemper liable for the ALJ's attorney fee award and awarded an additional attorney fee of $1,000 pursuant to ORS 656.308(2)(d).

In requesting reconsideration, claimant argues that his attorney also is entitled to a fee under ORS 656.382(2). Although "conced[ing] that not much time was spent by claimant's counsel in addressing [the compensability] issue," claimant seeks amendment of our order to include an assessed attorney fee for services on review regarding compensability.

We grant claimant's request. Because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue that was potentially at risk by virtue of our *de novo* review of the ALJ's order. *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993); *Larry W. Burke*, 49 Van Natta 1877, 2002 (1997) (because the ALJ's order addressed the compensability of the claimant's condition, the claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the potential compensability issue, even though the issue was not argued on review). After considering the factors in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $750, payable by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief--1/2 page was devoted to the issue), the nature of the proceedings, the value of the interest involved, the benefit secured for claimant and the risk that claimant's counsel might go uncompensated.

Accordingly, we withdraw our July 16, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our July 16, 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
PAUL E. SMITH, Claimant
Own Motion No. 99-0130M
OWN MOTION ORDER
Bottini & Bottini, Claimant Attorneys

The self-insured employer submitted a request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on January 9, 1994. The insurer opposed reopening on the grounds that: (1) it was not responsible for claimant's current condition; and (2) surgery or hospitalization was not reasonable and necessary for the compensable injury.

The employer denied the compensability of claimant's current condition on which claimant filed a request for hearing with the Hearings Division (WCB Case No. 99-02940). We postponed action on the own motion matter until pending litigation before the Hearings Division was resolved.

On August 2, 1999, Administrative Law Judge (ALJ) Tenenbaum approved a "Stipulation and Order" which resolved the parties' dispute pending before the Hearings Division. The employer agreed to rescind its compensability denial and "accept claimant's L4-5 disc herniation including appropriate benefits for the January 13, 1999 surgery." It further agreed to process claimant's "Own Motion claim referenced as No. 99-0130M" according to law. In addition, claimant's hearing request was dismissed with prejudice.

Based on the employer's rescission of its denial of claimant's L4-5 disc herniation, claimant's current neck condition has been determined to be compensable under his 1987 injury claim. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

On January 13, 1999, claimant underwent a laminectomy, foraminotomy and diskectomy at L4-5. Thus, we conclude that claimant's compensable injury worsened requiring surgery.[1]

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning January 13, 1999, the date he was hospitalized for surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

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[1] The employer initially opposed reopening of claimant's 1987 own motion claim on the ground that the recommended surgery was inappropriate medical treatment for claimant's current low back condition. We interpret the employer's statement "including appropriate benefits for the January 13, 1999 surgery," to mean that it is no longer contesting the appropriateness of claimant's surgery.

In the Matter of the Compensation of
JOHN W. FLAMMA, Claimant
WCB Case No. 97-10298
ORDER ON REVIEW
Willner, et al, Claimant Attorneys
Wallace, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Otto'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, which we supplement and summarize in pertinent part as follows.

On October 21, 1997, claimant discussed his problems and discomforts regarding tractors no. 7792 and 18221 with his supervisor by phone. On October 23, 1997, claimant refused to drive tractor no. 7792 on his usual run to Canada. On October 24, 1997, claimant wrote a letter to his supervisor complaining that newer trucks were sent on local runs, that tractor no. 7792 had been assigned to him, and that he was refusing to drive either of those tractors. In the letter, claimant stated that his hand "goes numb" and that the "rough ride is destroying my back and shoulders causing severe pain and stress." (Ex. 12A).

On November 9, 1997, claimant filed an Employee's Statement of Injury form alleging injury to his back as a result of driving to Canada on certain dates from October 1, 1997 to October 22, 1997. The employer received this form on November 16, 1997.

On November 13, 1997, claimant sought medical treatment from Dr. Hall, chiropractor, who diagnosed lumbar and thoracic strain/sprains. (Ex. 15). On November 15, 1997, claimant filed a form "801" with the employer. (Ex. 17).

On December 9, 1997, claimant sought treatment from Dr. Ushman, medical doctor, who diagnosed a lumbar sprain/strain. He stated that claimant's condition "probably" was the result of work. (Ex. 22).

On December 15, 1997, the employer denied compensability of claimant's back condition on the ground that his work activities were not the major contributing cause of his condition. (Ex. 24).

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's occupational disease claim compensable and assessed a 25 percent penalty against the employer for an allegedly unreasonable denial. On review, the employer contends that it had legitimate doubt regarding its liability. We agree.

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). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988).

On December 15, 1997, the employer issued a denial, asserting that claimant's work activities at the employer were not the major contributing cause of his condition. At the time the insurer issued the denial, it was aware that claimant had complained about, and refused to drive, two specific trucks in its fleet. The employer found no recent complaints filed regarding the tractor seats in its records and was

unable to find any problem with the seats on the tractors after physical inspection and a test drive. The employer was also aware that claimant had an outside oil-changing business, that claimant had not filed an injury report in October 1997, and that claimant had not sought treatment for his back until November 13, 1997.

Moreover, when the employer received medical reports from the doctors treating claimant, neither report indicated that claimant had sustained an injury. Dr. Nolan, chiropractor, reported low and mid back pain of three weeks' duration. Dr. Ushman indicated that claimant's back condition was "probably" due to work, based on claimant's history. Under these circumstances, we conclude that the insurer had a legitimate doubt as to whether claimant's back condition was compensable. *See Joseph H. Rettinger*, 51 Van Natta 87 (1999) (carrier's occupational disease denial not unreasonable when, at the time it issued, medical evidence did not satisfy required compensability standard of major contributing cause.) Therefore, claimant is not entitled to a penalty for an unreasonable denial.

ORDER

The ALJ's order dated February 9, 1999 is reversed in part and affirmed in part. That portion of the order assessing a 25 percent penalty for an unreasonable denial is reversed. The remainder of the order is affirmed.

Board Member Phillips Polich dissenting.

The majority concludes that claimant is not entitled to a penalty for an unreasonable denial. Because I believe that Exhibit 12A was sufficient to put the employer on notice of facts surrounding this claim, and the employer issued its denial without taking a statement to determine whether there were any other injuries that occurred during claimant's work at his own business, there was nothing in evidence at the time the denial issued to justify the denial. Therefore, I respectfully dissent.

Exhibit 12A is claimant's letter to his supervisor telling him that two specific tractors were causing him physical complaints. It is obvious from the doctor's notes and the form 827 that claimant's condition was work-related. (Exs. 15, 16, 18). But the ALJ noted --and the employer does not dispute-- that there is no evidence that the employer attempted to contact claimant or investigate the claim. Rather, as Mr. Reed admitted, he did not ask claimant about his business or whether he had ever been hurt in his business. An insurer has a duty to fully investigate the claim in order to determine a claimant's right to compensation. *Charles A. Tureaud*, 47 Van Natta 306, 307 (1995). Therefore, I would find that the employer failed to properly investigate the claim and would affirm the ALJ's assessment of a penalty for an unreasonable denial.

August 12, 1999 Cite as 51 Van Natta 1400 (1999)

In the Matter of the Compensation of
VERNA F. THOMAS, Claimant
Own Motion No. 95-0456M
OWN MOTION ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our July 22, 1999 Own Motion Order Reviewing Carrier Closure, that affirmed the insurer's March 18, 1999, 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
TROY A. HAMBY, Claimant
WCB Case Nos. 98-00661, 97-08852, 97-09054, 98-00342 & 98-00341
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Thaddeus J. Hettle, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillip Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld that portion of Liberty Northwest's denial that denied claimant's claim for right medial epicondylitis and right cubital tunnel syndrome; (2) upheld the SAIF Corporation's denial, on behalf of Keeton King, of claimant's claim for the same conditions; and (3) upheld SAIF's denial, on behalf of HDS Plaster, of the same conditions. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated February 18, 1999 is affirmed.

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's conclusion that claimant failed to prove the existence of his right arm medial epicondylitis condition. Based on the following reasoning, I respectfully dissent.

In a May 1, 1996 chartnote, Dr. Ferguson, who treated claimant following the July 1995 work injury, noted that claimant had tenderness over both the medial and lateral epicondyles. (Ex. 18). Based on this objective finding, Dr. Ferguson diagnosed medial epicondylitis. (*Id.*). In a May 17, 1996 chartnote, Dr. Ferguson reported that claimant no longer had medial epicondyle tenderness. (Ex. 21). In his deposition, Dr. Ferguson indicated that claimant had findings consistent with medial epicondylitis which subsequently resolved. (Ex. 83-37). In addition, Dr. Ferguson agreed that although claimant's medial epicondyle complaints resolved shortly after the May 1, 1996 examination, the 1995 work injury was the major cause of claimant's forearm and elbow complaints. (Ex. 83-17).

In *SAIF v. Strubel*, 161 Or App 516 (1999), the court held that a physician's opinion must be evaluated in the context in which is was rendered in order to determine its sufficiency. *See also WorldMark the Club v. Travis*, 161 Or App 644 (1999). Inasmuch as Dr. Ferguson treated claimant and had an accurate history of claimant's complaints in May 1996, his opinion supports the conclusion that claimant had medial epicondylitis which subsequently resolved. Since Dr. Ferguson opined that claimant's medial epicondylitis was work-related, I would find that claimant has established that his right medial epicondylitis condition is compensable.

In the Matter of the Compensation of
EDWARD I. PEARCE, Claimant
WCB Case No. 98-01167
ORDER ON REVIEW
Pozzi, Wilson & Atchison, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's order that upheld the SAIF Corporation's denials of his current "combined" low back condition. On review, the issue is compensability.

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

The ALJ upheld SAIF's denials of claimant's current combined low back condition, which included lumbar spondylosis and herniated discs at L5-S1 and L4-5. In so doing, the ALJ determined that the medical opinion of claimant's attending physician, Dr. Bert, was insufficient to establish that claimant's compensable January 16, 1997 injury was the major contributing cause of his need for treatment of the "combined" condition under ORS 656.005(7)(a)(B).

Although claimant contends on review that Dr. Bert's opinion is most persuasive, we agree with the ALJ's reasons for discounting his opinion. Moreover, in March 25, 1998 and July 6, 1998 reports, Dr. Bert attributed claimant's disc herniations to claimant's overall work activity, specifically lifting 150 pound hay bales and unloading feeding trucks.[1] (Exs. 42, 48AA). To the extent that Dr. Bert elsewhere concludes that claimant's compensable injury of January 16, 1997 is the major contributing cause of his current need for treatment (*e.g.* Ex. 55), we find Dr. Bert's opinion inconsistent and, therefore, unpersuasive.[2]

ORDER

The ALJ's order dated March 18, 1999 is affirmed.

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[1] Claimant did not assert an occupational disease claim at hearing. (O&O p. 2).

[2] The dissent argues that this case is controlled by *John M. Morley*, 50 Van Natta 1598, *corrected* 50 Van Natta 1702 (1998). We disagree. Our decision is based on the evidenciary record developed in this case. *See Ellen G. Johnson*, 49 Van Natta 1360, 1363 n.3 (1997). This record persuades us that Dr. Bert's opinion is inconsistent and, thus, insufficient to satisfy claimant's burden of proof (regardless of whether his claim is analyzed as a combined condition or as an occupational disease).

Board Member Phillips Polich dissenting.

The majority upholds SAIF's denial of claimant's current combined low back condition. In doing so, it agrees with the ALJ that the opinion of the attending physician and surgeon, Dr. Bert, is not persuasive. I disagree with both the ALJ's rationale for discounting Dr. Bert's opinion, as well as the majority's finding that Dr. Bert's opinion is inconsistent. Therefore, I must dissent.

A little background is necessary to put the claim in context. Claimant, a warehouseman, slipped off a step on January 16, 1997 while carrying a 25 pound bag of cat food. SAIF accepted a lumbar strain. In March 1997, an MRI revealed degenerative changes and disc abnormalities at L4-5 and L5-S1. Dr. Bert performed surgeries at those levels in July 1998, which included discectomies for herniated discs at L4-5 and L5-S1. SAIF later denied the compensability of claimant's current condition as well as lumbar spondylosis and the herniated disc conditions, despite Dr. Bert's insistence that claimant's low back conditon was related in major part to his work activity.

Applying ORS 656.005(7)(a)(B), the ALJ upheld SAIF's denials, finding Dr. Bert's opinion insufficient to satisfy claimant's burden of proof because it allegedly relied too heavily on a temporal relationship between the onset of low back symptoms and the January 16, 1997 incident of injury. For the following reasons, I do not share the ALJ's and the majority's concerns regarding the persuasiveness or sufficiency of Dr. Bert's analysis. *See SAIF v. Valencia*, 148 Or App 263 (1997).

First, Dr. Bert's status as attending physician is enhanced by his status as the surgeon who operated on claimant's low back and observed the herniated discs. The examining physicians who

provided a contrary opinion, Drs. White and Baker, obviously did not have the first-hand opportunity to view the surgical findings. For this reason alone, Dr. Bert's opinion is the most persuasive in this record. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988).

Second, despite the ALJ's suggestion to the contrary, a temporal relationship is not an impermisible basis on which to form an opinion on causation. *See Active Transportation Co. v. Wylie*, 159 Or App 12, 14-15 (1999). Moreover, Dr. Bert's opinion went far beyond mere chronological connection. Dr. Bert also relied on the nature of the work injury, the age of claimant, the MRI and surgical findings in forming his opinion. (Exs. 48AA, 55). Under current Oregon case law, this is sufficient to render his opinion persuasive. *See Bronco Cleaners v. Valazquez*, 141 Or App 295, 298-99 (1996); *Maxzime Honea*, 50 Van Natta 2025 (1998).

Third, Dr. Bert had observed claimant at work and possessed a complete understanding of not only claimant's work, but also the mechanism of injury. (Exs. 42, 48AA). Clearly, no other physician in this case had such familiarity with the nature of the work that produced claimant's compensable injury.

The majority asserts that Dr. Bert is inconsistent, citing his consideration of claimant's overall work activities. The majority's reservations notwithstanding, I find that Dr. Bert's consideration and first-hand knowledge of the nature of claimant's work activity only enhances an already persuasive opinion. The "Findings and policy" section of Chapter 656 specifically states that "[a]n exclusive, statutory system of compensation will provide the best societal measure of those injuries that bear a sufficient relationship to employment to merit incorporation of their costs into the stream of commerce." ORS 656.012(1)(c). Certainly, Dr. Bert's comments linking claimant's medical condition to his work activities bring it within the scope of coverage intended under the Oregon workers' compensation statutory scheme.

In sum, the ALJ's temporal relationship concerns and the majority's detection of an alleged inconsistency do not add up to a convincing basis for upholding SAIF's denials. The evidence supporting compensability (the fact that claimant injured his back while carrying a significant load, the changed nature of his symptoms, the MRI and surgical findings, and the persuasive opinion of the treating physician and surgeon) includes factors the Board has previously relied on in finding a claim to be compensable. *See John M. Morley*, 50 Van Natta 1598, *corrected* 50 Van Natta 1702 (1998). They should also result in a compensable claim in this case.

Because they do not, I, therefore, dissent.

August 12, 1999 Cite as 51 Van Natta 1403 (1999)

In the Matter of the Compensation of
LINDA J. WILLIAMS, Claimant
WCB Case No. 98-06508
ORDER OF ABATEMENT
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann, Defense Attorneys

Claimant requests reconsideration of our July 26, 1999 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of her bilateral hand and arm conditions. On reconsideration, claimant submits a July 12, 1999 report from Dr. Long that was not available at the time of hearing. She contends that the evidence of substantial improvement in her condition after cervical surgery proves that Dr. Long's analysis of causation was correct. Claimant also submits copies of additional medical records, including chart notes and reports from Dr. Keenen and a chart note from Dr. Fielder. Claimant requests remand to the ALJ for purposes of reopening the record and considering the new exhibits.

In order to consider this matter, we withdraw our July 26, 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.

In the Matter of the Compensation of
LAURA M. CLARK, Claimant
WCB Case No. 98-09502
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a right knee condition. On review, the issue is aggravation.

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

In the first sentence in the "Findings of Fact," we change "1998" to "1988."

We agree with the ALJ that the opinion of claimant's treating surgeon, Dr. Bert, was not sufficiently persuasive to carry claimant's burden of proof. Along with the reasons given by the ALJ, we base our decision on the following analysis.

First, we find the persuasiveness of Dr. Bert's opinion diminished by the lack of explanation concerning the absence of right knee symptoms. In this regard, orthopedic surgeon, Dr. James, who performed a record review, found that, if claimant had sustained a blow sufficiently severe to damage the patellofemoral joint, she would have experienced significant symptoms. (Ex. 29-7). We agree with Dr. James that the medical records do not support such a history. When claimant initially sought treatment, the emergency room physician found only moderate swelling. (Ex. 3). Claimant's treating physician, Dr. Bach, who next saw claimant, reported mild puffiness and tenderness. (Ex. 9). Until December 1997, there is no medical report showing that claimant sought treatment for her right knee and, on July 30, 1997, claimant's treating surgeon, Dr. Bert, stated that, according to claimant, she was "back to her preinjury status." (Ex. 14).

Dr. Bert also did not consistently explain the impact of any preexisting condition on claimant's need for treatment. In one report, Dr. Bert indicated that claimant did have some preexisting degenerative changes that combined with the 1997 injury. (Ex. 26). His last report, however, found that the 1997 injury was the major contributing cause of the degenerative changes and such changes could have developed between the date of surgery and the 1997 injury. (Ex. 30-3).

Because Dr. Bert's opinion does not respond to Dr. James' point concerning the lack of significant and continuous right knee symptoms and his opinion is inconsistent concerning any preexisting degenerative changes, we find persuasive reasons not to defer to Dr. Bert's opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). Thus, at best, we find the medical opinion evidence in equipoise and we agree with the ALJ that claimant did not carry her burden of proving a compensable aggravation.

ORDER

The ALJ's order dated March 29, 1999 is affirmed.

Board Member Phillips Polich dissenting.

Because I disagree with the majority that Dr. Bert's opinion is not sufficient to carry claimant's burden of proof, I respectfully dissent.

On January 9, 1997, claimant was compensably injured in a head-on motor vehicle collision, in which impact was estimated at 25 m.p.h. Her right knee struck the dash board and the vehicle's air bags inflated. Claimant was taken by ambulance to the emergency room. Along with bilateral arm pain and anterior chest pain, she experienced right knee pain. Claimant's right knee was x-rayed, but showed no evidence of an acute fracture or dislocation. In February 1997, SAIF accepted a nondisabling claim for bilateral arm abrasions, anterior chest abrasions, bruising and right knee contusion.

After the accident, claimant experienced back pain and swelling and bruising of her right knee. Her right knee condition got progressively worse, prompting her to mention the problem to Dr. Bert, who had been treating her low back pain. In June 1997, Dr. Bert diagnosed chondromalacia with crepitus under the patella. On July 30, 1997, Dr. Bert found that claimant was medically stationary.

In February 1998, claimant returned to Dr. Bert, and reported that her knees were still "hanging up" and that the right knee had locked a couple of times. In April 1998, Dr. Bert again noted that claimant's knees were "hanging up" on her. Dr. Bert reported that this problem was directly related to the January 1997 compensable accident. He completed an aggravation claim on claimant's behalf on April 22, 1998.

In May 1998, claimant was evaluated by Dr. Donahoo at SAIF's request. Nearly a year and a half after the accident, Dr. Donahoo, found some "subcutaneous fatty necrosis" during his examination that he thought was compatible with an impact injury. He reported that the motor vehicle accident could have caused some patellofemoral changes and agreed that an arthroscopic debridement would be appropriate.

Although Drs. Donahoo and James opined that claimant's motor vehicle accident was not the major contributing cause of her current right knee condition, I believe that they do not have a complete understanding of the severity of the collision. Based on the absence of effusion immediately after the incident, they concluded that claimant did not sustain any significant injury to the right knee and that the impact was not a "major event." (*See* Ex. 25-2). But the uncontroverted facts show that this was a severe collision. I also find it significant that claimant had continued bruising on her right knee a year and a half after the accident. Neither Dr. Donahoo nor Dr. James explains why claimant would have such findings if the compensable injury did not continue to be the major contributing cause of the need for treatment.

I also disagree with the majority's determination that Dr. Bert did not consistently explain the contribution from the preexisting condition. Granted, the record establishes that claimant likely had some preexisting degenerative changes of the right knee, but there is no evidence that claimant's right knee condition was severe until after the accident.[1] Dr. Bert found Grade IV changes when he operated on claimant's right knee in June 1998, eighteen months after the injury. He believed that these degenerative changes were caused in major part by the motor vehicle accident. Dr. Bert explained that, in his opinion, claimant's clinical presentation did not support Dr. Donahoo's opinion that she had a significant degree of degeneration of the right knee as of January 1997, because if she had such substantial degenerative changes prior to the injury, she would have had experienced continuous symptomatology in her right knee that would likely have been reported. (Ex. 30-4). Dr. Bert also opined that it is reasonably medically probable that claimant's Grade IV degenerative findings developed within the one and a half years between the injury and the June 1998 surgery. *Id.* Finally, Dr. Bert explained that the absence of effusion of the right knee shortly after the accident (a factor Dr. Donahoo found significant) does not necessarily mean that claimant did not experience a traumatic injury to the knee. In Dr. Bert's practical experience, joint effusion may not occur for hours or days after a traumatic injury and sometimes not at all. (Ex. 30-3).

In sum, I find Dr. Bert's opinion well-reasoned and based on an accurate history and understanding of the severity of the collision. I therefore find no persuasive reason not to defer to his opinion, and would conclude that claimant met her burden of proof.

---

[1] Claimant did report some locking and catching of her right knee in 1988 and an injury in 1989, but these symptoms resolved. By July 1989, she had full range of motion, no pain and could walk without difficulty. Br. Bert opined that these earlier right knee problems were unrelated to claimant's current right knee condition. (Ex. 30-2). Even Dr. James noted that it would be impossible to draw any conclusions as to the extent of her preexisting condition from these two incidents. (Ex. 29-8). The record contains no evidence that claimant had any further need for treatment of her right knee prior to the January 1997 motor vehicle accident.

In the Matter of the Compensation of
SHANNON DAHLQUIST, Claimant
WCB Case No. 98-05105
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Otto's order that set aside its partial denial of claimant's claim for muscle contraction cephalgia, occipital neuralgia and thoracic outlet syndrome (TOC). In her brief, claimant challenges that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

On review, claimant contends that the ALJ erred in not assessing a penalty for the insurer's denial of her muscle contraction cephalgia, occipital neuralgia and thoracic outlet syndrome. The ALJ declined to assess a penalty based on the deposition testimony of treating physician Dr. Aversano that claimant did not require treatment for her headaches and TOC. Claimant contends that, because such evidence was generated after the denial, it should not be considered in deciding whether the denial was unreasonable at the time it issued.

Pursuant to ORS 656.262(11)(a), if a carrier unreasonably denies a claim for compensation, it shall be liable for an additional amount of the amounts then due. 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 (1998). The assessment of the reasonableness of the carrier's actions is based on the information available to the carrier at the time of its denial. *See Norgard v. Rawlinsons*, 30 Or App 999 (1977) (unreasonableness and legitimate doubt are to be considered in the light of all the evidence available to the carrier at the time of its action). It is claimant's burden to prove that the carrier acted unreasonably. *Harris v. SAIF*, 292 Or 683 (1982).

The employer issued its denial of claimant's cephalgia, occipital neuralgia and TOC on June 17, 1998. As of that date, Dr. Aversano had diagnosed "cervico-dorsal strain/sprain, secondary to injury of 3.31.98 with secondary muscle contraction cephalgia and occiptal neuralgia and secondary thoracic outlet syndrome producing intermittent numbness in the arms and hands." (Ex. 9-2).

Because Dr. Aversano stated that the additional conditions were "secondary" to a compensable condition, we interpret his report as indicating that such conditions arose after the injury and, thus, constituted "consequential conditions" under ORS 656.005(7)(a)(A). Consistent with this approach, claimant's attorney asked the employer to accept the additional conditions as "new medical conditions." Under ORS 656.005(7)(a)(A), claimant must show that the compensable injury is the major contributing cause of the consequential condition.

We do not find Dr. Aversano's report sufficient to show that, when it issued its denial, the employer had no legitimate doubt that the compensable injury was the major contributing cause of the additional conditions. First, only Dr. Tobin, who treated claimant before she saw Dr. Aversano, diagnosed claimant with any of the conditions found by Dr. Aversano. Moreover, although Dr. Tobin diagnosed cephalgia, she attributed it to "probably tension." (Ex. 6-3). Dr. Puziss, who saw claimant on referral from Dr. Tobin after Dr. Aversano's examination, diagnosed only left shoulder and cervical strains, as well as internal derangement of the left shoulder. (Ex. 11-2).

Furthermore, we are not convinced that Dr. Aversano's use of the word "secondary" necessarily means "major contributing cause." Because we find that Dr. Aversano's report is ambiguous as to the extent of contribution from the compensable injury, we find that the employer had legitimate doubt as to whether claimant had satisfied ORS 656.005(7)(a)(A). *See Joseph H. Rettinger*, 51 Van Natta 87, 88 (1999) (carrier had legitimate doubt because medical evidence did not satisfy the compensability standard for the claimant's occupational disease claim). Consequently, we conclude that the employer's denial is not unreasonable.

Finally, 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 $1,200, payable by the employer. 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 March 12, 1999 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the employer.

In the Matter of the Compensation of
JOSEPHINE KREUGER, Claimant
WCB Case No. 98-02509
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the insurer's denial of claimant's current neck and upper back condition. Claimant also objects to the ALJ's admission of Exhibit H. On review, the issues are evidence and compensability.

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

As she did at hearing, claimant objects to the ALJ's admission of Exhibit H, a report dated October 26, 1993 from Dr. Caserta, chiropractor. In the report, Dr. Caserta describes claimant's symptoms and treatment following an accident, and includes Dr. Caserta's diagnosis of chronic cervical musculoligamentous sprain/strain. According to claimant, the ALJ abused his discretion in admitting the report because: (1) the insurer did not exercise "due diligence" in obtaining the report; (2) claimant's remaining chartnotes and records from Dr. Caserta's treatment were not available, thereby "prejudicing" claimant in obtaining evidence from Dr. Caserta; and (3) at the time the exhibit was admitted, the record had been left open only for admission of three depositions.

The hearing initially convened on June 22, 1998. Another hearing convened on August 7, 1998; the ALJ explained that the hearing had been continued for closing arguments and the record was held open for the admission of three depositions. (Tr. 1). The ALJ also stated that the insurer's attorney at that time sought to admit additional exhibits, including Exhibit H. (*Id.*) Claimant objected. The ALJ admitted Exhibit H and continued the hearing to allow claimant to depose Dr. Caserta and submit any additional testimony or documents. (*Id.* at 18-19).

On January 8, 1999, the last hearing convened, where the ALJ admitted Dr. Caserta's deposition transcript. Claimant also testified and discussed the 1993 accident and treatment with Dr. Caserta.

At the hearing, the ALJ has discretion to admit additional medical reports or other documentary evidence not disclosed as required by OAR 438-007-0015.[1] OAR 438-007-0018(4). In exercising this discretion, the ALJ determines whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party or parties. *Id.* Following a finding of material prejudice, the ALJ may exclude a document or continue the hearing for such action as is appropriate to cure the material prejudice caused by the late disclosure of the document.

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[1] Under this rule, the carrier must provide all documents within 15 days of receiving the request for hearing or demand for production. OAR 438-007-0015(2). After this initial exchange, additionally acquired documents must be provided within seven days of receipt of the documents. OAR 438-007-0015(4).

Thus, because claimant objects to the ALJ's admission of an additional medical report offered at hearing, we examine whether the ALJ abused his discretion. Under this standard, the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice. ORS 656.283(7); *Brown v. SAIF*, 51 Or App 389, 394 (1991).

We find no abuse of discretion by the ALJ in admitting Exhibit H. Any "material prejudice" in admitting this exhibit was cured by the ALJ's continuance of the hearing to allow claimant to obtain Dr. Caserta's deposition; this continuance also allowed claimant to testify and provide rebutting evidence about Exhibit H. Given these facts, the admission of Exhibit H did not prevent the hearing as a whole from achieving substantial justice.

Furthermore, even if we agreed with claimant and did not consider Exhibit H, we would come to the same conclusion concerning the merits of the case. As the ALJ noted, other evidence also documented claimant's complaints of neck pain at the time of the 1993 accident. (Ex. B-2, C-3). Claimant also does not object to the admission of Dr. Caserta's deposition, which essentially provides the same evidence as Exhibit H in that Dr. Caserta affirmed the accuracy of the report's description of claimant's neck pain and the diagnosis of cervical sprain/strain. (Ex. 62-42, 62-30-31).

Finally, along with the ALJ's analysis of the medical opinions, we find additional reasons for not deferring to Dr. Singer's opinion. In her deposition, Dr. Singer described claimant's condition as "chronic pain syndrome." (Ex. 61-9). When asked about the cause of such a condition, Dr. Singer explained that it was "a multifactorial problem with both physical, psychological, and probably neurologic components." (*Id.* at 11). In later explaining the difference between a chronic cervical strain and a chronic pain syndrome, Dr. Singer stated that the latter condition "would include the dependence on narcotics and other medications to maintain pain management and the psychological effects of being in chronic pain." (*Id.* at 25).

Although Dr. Singer also found that claimant's compensable injury was the major contributing cause of her current condition, we find that her discussion concerning claimant's chronic pain syndrome condition shows that numerous factors were involved, including dependence on narcotics and psychological effects. Because Dr. Singer did not explain why, when claimant's condition was "mulitfactorial," the compensable injury was the major contributing cause, we find her opinion not to be well-reasoned.

Moreover, Dr. Singer also stated that she attributed the current condition to the compensable injury because claimant was asymptomatic before the event and the onset of her symptoms were contemporaneous with the compensable injury. We find such an opinion to be based only on a temporal relationship, a basis we also do not consider to be persuasive. *See Bradshaw v. SAIF*, 69 Or App 587, 589 (1984) (causation not logically inferred from temporal sequence unless all other explanations excluded).

In sum, we agree with the ALJ that claimant did not carry her burden of proving compensability.

ORDER

The ALJ's order dated January 20, 1999 is affirmed.

In the Matter of the Compensation of
JOANN K. RUSSUM, Claimant
WCB Case No. 97-09563
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that awarded claimant permanent total disability, whereas an Order on Reconsideration awarded 21 percent (67.2 degrees) unscheduled permanent disability for a low back injury. In its brief, the employer requests an offset for an asserted overpayment of permanent disability. On review, the issues are extent of permanent disability, including permanent total disability, and offset. We reverse.

FINDINGS OF FACT

Claimant compensably injured her low back on December 13, 1991, when she lifted a heavy tray of baked goods at work. She returned to modified work, which she performed until about February 1992. In March 1992, the employer accepted a disabling low back strain. On April 9, 1992, Dr. Hill performed a lumbar laminectomy and diskectomy for a large herniated fragment at L1-2 on the right.

Claimant subsequently developed problems with her right shoulder, for which she treated with Dr. Schader. After litigation, the right shoulder condition was found compensable. By February 1995, Dr. Schader concluded that the shoulder condition had resolved.

Meanwhile, on August 2, 1993, the employer offered claimant a modified job approved by Dr. Schader. Claimant declined the job because she was moving and did not feel capable of performing work on a regular basis.

Claimant continued to have back problems for which she received nerve root injections. On May 17, 1994, Dr. Hill requested permission to do a nerve root decompression and foraminotomy at L5. The surgery was authorized, and, on March 22, 1995, Dr. Hill performed a lumbar laminectomy at L5-S1 on the right with foraminal decompression of the L5 nerve root. Claimant continued to experience low back and right groin pain. Dr. Hill diagnosed scarring of the L5 nerve root. Further conservative treatment did not improve claimant's low back condition.

On May 19, 1995, the parties entered into a stipulation in which the employer agreed to accept the L5 surgery as a compensable consequence of the December 1991 injury and to process the claim according to law. The employer did not pay temporary disability benefits and claimant requested a hearing. Relying on the stipulation, in which claimant agreed that no temporary disability was due because she declined the 1993 modified job offer, a prior ALJ concluded that claimant did not lose any wages when she had the 1995 surgery. The Board affirmed.

Claimant applied for Social Security Disability benefits. On December 11, 1995, after reviewing his records, Dr. Long opined that claimant had not been able to engage in any substantial gainful work activity on a reasonably regular basis since December 1, 1992 through March 11, 1995 because of her L5 radicular condition. Claimant was granted Social Security disability benefits on December 21, 1995.

On February 14, 1996, Dr. Mayhall performed a closing examination. He found claimant capable of sedentary work and declared her medically stationary. On May 6, 1996, Dr. Hill concurred in Mayhall's report.

On April 29, 1996, claimant returned to Dr. Long with complaints of neck and back pain and numbness. A July 3, 1996 myelogram and CT scan revealed post-operative changes at L5-S1 on the right but no evidence of nerve root compression in the cervical or lumbar regions.

On February 11, 1997, Dr. Hill agreed with Dr. Long that claimant had not been capable of substantial gainful employment since December 1, 1994. (Ex. 185).

The employer issued an Updated Notice of Acceptance on December 9, 1997, as modified January 23, 1998, that identified the accepted conditions as disabling lumbar strain, L1-2 disc herniation, disabling nerve root decompression of L5 and foraminotomy, and right shoulder adhesive capsulitis.

On December 10, 1997, Drs. Strum and Wilson examined claimant for the employer.

A December 23, 1997 Determination Order closed claimant's 1991 injury claim with a May 6, 1996 medically stationary date and an award of 35 percent unscheduled permanent disability and temporary disability from December 14, 1991 through July 13, 1994. Claimant requested reconsideration, raising the issues of permanent partial and permanent total disability.

On February 17, 1998, claimant's vocational consultant, Richard Ross, assessed claimant's vocational potential. On March 31, 1998, the employer's vocational consultants, Anthony Pfannensteil and Patricia Ayerza, assessed claimant's vocational potential. On April 6, 1998, Dr. Dupuis performed a medical arbiter examination.

A May 13, 1998 Order on Reconsideration reduced the unscheduled permanent disability award to 21 percent and declined to find claimant permanently and totally disabled on the grounds, among others, that claimant had not shown that she had made efforts to work or that she was willing to work. Claimant requested a hearing, raising the issues of scheduled and unscheduled permanent partial disability and permanent total disability. The employer cross-requested an offset for any overpayment of permanent disability over the 21 percent awarded by the May 13, 1998 Order on Reconsideration.

The parties agreed to submit the matter to the ALJ on the record and closing arguments.

Claimant, age 58 at hearing, completed 11 years of formal education and has not obtained a diploma or GED. In the past five years she worked as a reception clerk and a bakery counter clerk.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant was permanently and totally disabled, finding that the medical and vocational evidence established that claimant was precluded from regularly performing any work at a gainful and suitable occupation. On review, the employer argues that claimant retains some residual functional capacity and is, therefore, not permanently and totally disabled based on medical factors alone or a combination of medical and non-medical factors. The employer also argues that we should reinstate the Order on Reconsideration's award of 21 percent unscheduled permanent disability and authorize an offset for any overpayment of compensation paid under the Notice of Closure that awarded 35 percent unscheduled permanent disability.

Permanent Total Disability

We agree with the employer that claimant has not established that she is permanently and totally disabled, but for the following reasons.

"Permanent total disability" is 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). In order to establish permanent total disability (PTD), claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. In addition, before a claimant is entitled to PTD he or she must establish that, but for the compensable injury, he or she (1) is or would be willing to seek regular gainful employment and (2) has or would have made reasonable efforts to obtain such employment. ORS 656.206(3);[1] OAR 436-030-0055(3);[2] *SAIF v. Scholl*, 92 Or App 594 (1988).

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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." (Emphasis added.)

[2] OAR 436-030-0055 provides in pertinent part:

"(3) In order for a worker to be determined permanently and totally disabled, a work must:

"(a) prove permanent and total disability;

"(b) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and

"(c) Be willing to seek regular and gainful employment."

A claimant who is so incapacitated that he or she cannot perform regular gainful employment need not establish that he or she "has made reasonable efforts to obtain such employment" because seeking such work would be futile. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 307 (1985). Such a claimant, however, must establish that he or she, but for the compensable injury, is or would be willing to seek regular gainful employment. ORS 656.206(3); OAR 436-030-0055(3)(c); *SAIF v. Stephen*, 308 Or 41 (1989). In other words, a finding of futility alone is not sufficient to support an award of permanent and total disability benefits, as a finding that claimant is willing to work is a prerequisite to entitlement to such benefits. *Champion International v. Sinclair*, 106 Or App 423 (1991).

Claimant has the burden to prove the nature and extent of her disability. ORS 656.266. Here, the ALJ determined that claimant is unable to work, even part time, based on medical and vocational factors. Assuming that claimant has otherwise established that she is incapacitated from regularly working based on the "odd lot" doctrine (or even solely on medical factors), we would nonetheless conclude that she has not proven entitlement to permanent total disability benefits because there is no persuasive evidence that she is "willing to work" within the meaning of ORS 656.206.

Claimant has worked as a receptionist and bakery clerk in the past. After her 1991 injury, claimant returned to modified work until she was taken off work in February 1992. But in February 1993, claimant reported to a physicial capacities examiner that she had "not really thought about returning to work in any capacity because of her current physical condition and was unable to identify any potential vocational goals." (Ex. 80). Moreover, when Dr. Long and Dr. Schader released her to an approved modified job in September 1993, she declined to take the job for reasons unrelated to her physical condition. (Exs. 84, 190-4).

In April 1994, Dr. Long reported that claimant had not gone back to work, and, in June 1994, Dr. Wilson opined that claimant could return to full gainful employment if she so desired, but found it unlikely that she would make any attempt to do so. (Exs. 125, 135).

Claimant subsequently applied for Social Security disability benefits. In December 1995, after reviewing his records, Dr. Long changed his earlier opinion, now stating that claimant had not been able to engage in any substantial gainful work activity on a regular basis since December 1, 1992 through March 11, 1995, noting that he had no current physical capacities or neurological status for her. (Ex. 148). On December 21, 1995, claimant was granted Social Security disability benefits.

On February 14, 1996, Dr. Mayhall performed a closing examination. He declared claimant medically stationary and opined that she could return to sedentary work. Treating neurosurgeon Dr. Hill concurred. (Exs. 157-6, 168).

In June 1996, when claimant returned to Dr. Long for evaluation of her back and a new neck condition, he noted that claimant had been judged permanently disabled by the Social Security Administration, and identified her work status as "disabled from regular and modified work."[3] (Exs. 165, 171, 179). Upon referral for surgical evaluation, Dr. Hill reported that claimant had been "retired for the last five years." (Ex. 172). But in February 1997, Hill, like Long, also changed his earlier opinion about claimant's ability to work, stating that he had not seen claimant since June 1996 and that he agreed with Dr. Long that claimant had not been capable of substantial gainful employment since December 1, 1994. (Ex. 185).

In April 1998, Dr. Dupuis, medical arbiter, concluded that claimant was capable of light/sedentary work, and for the same number of hours she worked prior to her injury. (Ex. 212).

Although claimant's vocational examiner, Mr. Ross, opined that claimant was unable to sustain even part time work based on his testing and assessment of claimant's ability to perform work over a three and one-half hour period, there is nothing in his report to indicate that "but for" claimant's compensable conditions she would be willing to work. (Ex. 120).

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[3] In June 1996, claimant had new complaints related to her neck and left arm, which are not considered in evaluating her PTD status. *Elder v. Rosboro Lumber Co.*, 106 Or App 16 (1991); *Darlene E. Parks*, 47 Van Natta 2404, 2408 (1995), *recon den* 48 Van Natta 190 (1996) (the claimant must prove that his or her permanent total disability is due to her compensable injury).

In summary, as discussed above, the evidence fails to establish that claimant was willing to work. Because claimant has not carried her burden to prove that she was "willing to work" within the meaning of ORS 656.206(3), we conclude that her claim for permanent total disability compensation must fail.

Unscheduled Permanent Disability

On review, the employer contends that the Order on Reconsideration's award of 21 percent unscheduled permanent disability should be reinstated. Claimant contends that the award should be increased to the 35 percent awarded by the Determination Order. We disagree.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure or other physicians with whom the attending physician concurs. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666, 670 (1994). Reports of insurer-arranged medical examiners may not be considered in rating impairment unless those findings are ratified by the claimant's attending physician. *Tektronix, Inc. v. Watson*, 132 Or App 483 (1995). Consequently, we do not consider the December 10, 1997 report by Drs. Strum and Wilson.

Evaluation of a worker's disability is as of the date the reconsideration order issues. ORS 656.283(7); 656.295(5). The February 1996 report by Dr. Mayhall, in which Dr. Hill concurred, was provided over two years before the May 13, 1998 Order on Reconsideration. Furthermore, as discussed above, more recent evidence from Dr. Hill is inconsistent with his concurrence in the February 1996 report. Consequently, we rely on the arbiter's report for more persuasive evidence concerning claimant's impairment provided closer in time to the Order on Reconsideration.

Disability standards adopted by the Director that are in effect at the time of claim closure are used in determining claimant's permanent disability. ORS 656.283(7); ORS 656.726(3)(f)(A). Claimant's claim was closed by Determination Order dated December 23, 1997. Therefore, her claim is properly rated under WCD Admin. Order 96-072 (eff. February 15, 1997). OAR 436-035-0003(2) and (3).

Based on the medical arbiter's report, the Order on Reconsideration found that claimant's total impairment value for the right shoulder was 1.3, rounded down to 1 percent. After reviewing the findings, we affirm this value for shoulder impairment. *Former* OAR 436-035-0007(22); 436-035-0330(1), (3), (5), (7), (9), (11), (15); 436-035-0007(14).

The medical arbiter also noted reduced lumbar ranges of motion. However, he concluded that his measurements were invalid due to marked inconsistencies, positive Waddell's signs, give way weakness, and claimant's voluntary lack of effort. (Ex. 212-6, -7). Thus, we agree with the Order on Reconsideration's zero percent impairment value for loss of motion in the lumbar spine. *Former* OAR 436-035-0007(27); *Harvey Clark*, 47 Van Natta 136 (1995) (where the medical arbiter found the claimant's range of motion findings invalid, the claimant failed to prove impairment).

Claimant underwent a laminectomy and discectomy and L1-2 and a laminectomy at L5. The total value for these surgeries is 10 percent. *Former* OAR 436-035-0350(2).

Combining the impairment value for the lumbar surgeries with that for the right shoulder, the total impairment value is 11 percent. *Former* OAR 436-035-0007(14) through (17).

We next address the non-impairment factors of age, education and adaptability.

Age: At the time of claim closure, claimant was over 40 years old, which is rated as a value of 1. *Former* OAR 436-035-0290(2).

Education: Claimant did not hold a high school diploma or GED certificate, which is rated as a value of 1. *Former* OAR 436-035-0300(2)(b). She worked as a Bakery Sales Clerk (DOT 290.477-018), SVP 3, at the time of injury. This was the highest SVP she had attained in the five years prior to injury, and is rated as a value of 3. *Former* OAR 436-035-0300(3), (4). The age and education values are added, for a total value of 5.

Adaptability: Claimant's base functional capacity (BFC)as a Bakery Sales Clerk was Light. Her residual functional capacity (RFC) is Light/sedentary. In comparing claimant's BFC to her RFC, the value for adaptability is 2. *Former* OAR 436-035-0310(2) through (7).

We now assemble the factors. The total for age and education (5) is multiplied by the value for adaptability (2) for a total value of 10 for non-impairment factors. This value is added to the impairment value of 11 for a final value of 21 percent unscheduled permanent disability. *Former* OAR 436-035-0280. We accordingly reinstate the Order of Reconsideration's 21 percent unscheduled permanent disability award.

Offset

The employer requests an offset for any compensation paid to claimant under the Determination Order that awarded 35 percent unscheduled permanent disability.

Here, the Order on Reconsideration authorized the employer to deduct any overpaid temporary disability benefits or previously paid permanent disability benefits from the permanent disability awarded by the Order on Reconsideration. Thus, pursuant to ORS 656.268(15)(a)[4], the employer is entitled to offset any overpaid permanent disability. *E.g., Adam J. Delfel,* 50 Van Natta 1041, 1045 (1998).

ORDER

The ALJ's order dated December 14, 1998 is reversed. The permanent total disability and attorney fee awards are reversed. The Order on Reconsideration is reinstated and affirmed.

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[4] ORS 656.268(15)(a) provides:

"An insurer or self-insured employer may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer. When overpayments are recovered from temporary disability or permanent total disability benefits, the amount recovered from each payment shall not exceed 25 percent of the payment, without prior authorization from the worker."

August 18, 1999 Cite as 51 Van Natta 1413 (1999)

In the Matter of the Compensation of
SOPHIE M. BUCK, Claimant
WCB Case Nos. 99-00324 & 98-06521
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

CNA Insurance Company (CNA) requests review of those portion of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's current right wrist condition, and; (2) upheld Kaiser Permanente's (Kaiser) denial of the same condition. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to assess a penalty against Kaiser for allegedly unreasonable claims processing, and; (2) declined to assess a penalty against CNA for an allegedly unreasonable denial. On review, the issues are compensability, responsibility, and penalties.

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

Claimant asserts that CNA did not have a legitimate doubt as to its ongoing liability for claimant's accepted right wrist condition and therefore contends that a penalty is warranted. We disagree.

A penalty is appropriate if a carrier does not have a legitimate doubt as to its liability. *Brown v. Argonaut Insurance Company,* 93 Or App 588 (1988). The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of its denial. *Price v. SAIF,* 73 Or App 123, 126 n. 3 (1985).

At the time it issued its denial of claimant's current condition, CNA had a letter signed by claimant which indicated that she had made a full recovery from her accepted right wrist condition. (Ex. 9). In addition, CNA was also aware that claimant was performing keyboarding tasks for a different employer at the time she filed her claim for aggravation. (Exs. 15, 23). Finally, the insurer possessed medical opinions from Dr. Button which indicated that claimant's condition was not work-related. (Exs. 29, 34). Under these circumstances, we conclude that CNA had a legitimate doubt regarding its liability for claimant's current right wrist condition. Accordingly, a penalty is not warranted.

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

ORDER

The ALJ's order dated March 15, 1999 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,500, payable by CNA Insurance Company.

[1] We note that claimant's counsel's statement of services does indicate the amount of time spent on the penalty issues for which claimant's counsel is not requesting an assessed attorney fee under ORS 656.382(2). Claimant is not entitled to an attorney fee for her counsel's unsuccessful services on review regarding the penalty issues.

In the Matter of the Compensation of
DONNA M. JOHNSTON, Claimant
WCB Case No. 98-06018
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The self-insured employer (JCI) requests review of Administrative Law Judge (ALJ) Livesley's order that set aside its denials of compensability and responsibility for claimant's occupational disease claim for bilateral hand conditions (left trigger thumb, right trigger thumb and middle finger).[1] 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, which we supplement and briefly summarize as follows.

Claimant, age 39 at hearing, has always worked with her hands. (Tr. 21). On September 15, 1997, she began working for JCI on its battery assembly lines, first as a case puncher, then, beginning November 15, 1997, as a battery loader. The battery loader job required rapid, repetitive gripping and lifting of two to four-pound stacks of lead battery plates with each hand. (Tr. 23 to 31; Ex. 8A). After her first day as a battery loader, claimant experienced hand pain; after about two weeks, hand numbness; and after about three weeks she was unable to straighten her left thumb, her right thumb would not bend, and her right middle finger began to lock. (Tr. 33 through 36). Claimant was laid off on January 10, 1998.

On January 29, 1998, claimant began working for Oroweat as a packer. This job entailed rapid use of the hands and arms to fill trays with packages of rolls. (Tr. 69 through 71).

[1] Claimant elected not to file a claim against her current employer, Oroweat.

On February 16, 1998, claimant sought treatment for her hands from Dr. Phillips, her attending physician, who referred her to occupational therapy. On March 13, 1998, claimant complained to occupational therapist Klof of bilateral thumb pain associated with gripping and lifting, numbness, stiffness, swelling and weakness. Klof noted that claimant was currently using her hands for lifting and grasping at work, but generally used her thumbs in an adducted-type grasp to avoid pain with opposition-type grasp. (Ex. 3).

On March 20, 1998, Dr. Neuberg, occupational medicine specialist, examined claimant. Neuberg diagnosed bilateral tendinitis, which she related to claimant's intense repetitive gripping at JCI by history. (Ex. 4). On the same date, claimant filed a claim with JCI. (Ex. 5).

On May 4, 1998, Dr. Yamanaka, orthopedist, evaluated claimant's condition for possible surgical correction. He diagnosed bilateral trigger thumb and a triggering right middle finger, and injected cortisone into each thumb. He recommended surgery if the injections were ineffective. (Ex. 11).

On July 7, 1998, Dr. Nolan examined claimant for JCI. (Ex. 13).

On July 24, 1998, JCI denied compensability and responsibility. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant elected not to join her current employer, Oroweat, as a party. Instead, she chose to prove actual causation against JCI. Relying on Dr. Neuman's opinion, the ALJ found claimant's occupational disease claim for bilateral trigger thumbs compensable. The ALJ also found JCI responsible, reasoning that, although claimant's work at Oroweat could have contributed to claimant's condition, there was no evidence that it actually did contribute. Opinion and Order at 5. On review, JCI contends that Dr. Neuberg's opinion is insufficient to establish compensability, and that it is not responsible for the claim.

Compensability

We adopt and affirm the ALJ's opinion on this issue, with the following comment. The ALJ found that claimant credibly testified that she first experienced symptoms in her hands when working at JCI. Claimant also credibly testified that her work at Oroweat, although requiring rapid use of her hands and arms, was much less intense than her work at JCI, and that her hand condition had improved at her Oroweat employment. (Tr. 69 through 79). There is no contrary evidence. Consequently, the record as a whole supports Dr. Neuberg's opinion establishing the compensability of claimant's occupational disease claim.

Responsibility

JCI contends that initial responsibility should be assigned to Oroweat, because claimant first sought medical treatment for her trigger fingers while employed at Oroweat.[2] JCI further contends that the record does not establish either that it was impossible for claimant's work at Oroweat to have caused or contributed to her triggering condition, or that claimant's previous work under JCI was the sole cause of her condition. 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). Consequently, we turn to the last injurious exposure rule (LIER) to resolve this dispute.

Dr. Nolan assessed the contribution between claimant's work at JCI and Oroweat, stating that claimant's employment at Oroweat contributed to her trigger fingers. (Ex. 17-3). That is sufficient to invoke defensive use of LIER as a rule of responsibility. *Safeco Ins. Co. v. Victoria*, 154 Or App 574 (1998). Under that rule, responsibility for claimant's bilateral hand condition is initially assigned to the last potentially causal employment. If an injured worker receives medical treatment before experiencing time loss due to the condition, then the date of first medical treatment is determinative for assigning initial responsibility. *Timm v. Maley*, 125 Or App 396, 401, *rev den* 310 Or 81 (1994).

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[2] We note at the outset that ORS 656.308(1) is not applicable because there is no prior accepted compensable injury. *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).

Here, claimant first sought medical treatment for her trigger finger condition in February 1998, while she was employed at Oroweat. (Ex. 3). Therefore, initial responsibility would be assigned to Oroweat. *Timm*, 125 Or App at 401. In order for responsibility to be shifted to JCI, it must be established that it was impossible for claimant's work at Oroweat to have caused the condition or that claimant's work at JCI was the sole cause of the condition. *Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Reynolds Metals*, 157 Or App at 153.

Because the record does not establish that it was impossible for claimant's employment at Oroweat to cause her condition or that her prior employment at JCI was its sole cause, responsibility remains with Oroweat. *See Betty L. Martinez*, 50 Van Natta 1535, *on recon* 50 Van Natta 1657 (1998) (rejecting the carrier's argument that it was not responsible for the claimant's right carpal tunnel syndrome because the claimant's work for that carrier did not in fact cause the condition).

Accordingly, JCI is not responsible for claimant's bilateral triggering condition.

ORDER

The ALJ's order dated March 16, 1999 is reversed in part and affirmed in part. JCI's, the self-insured employer's, responsibility denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

August 18, 1999 Cite as 51 Van Natta 1416 (1999)

In the Matter of the Compensation of
DAVID G. McDONALD, Claimant
WCB Case No. 98-05957
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the SAIF Corporation's denial of claimant's left shoulder injury claim; and (2) declined to award interim compensation between April 3, 1998 and April 21, 1998. On review, the issues are compensability and interim compensation.

We adopt and affirm the ALJ's order with the following supplementation to address claimant's argument on review regarding the interim compensation issue.

The ALJ found that SAIF's cessation of interim compensation as a result of Dr. Peterson's release to regular work was appropriate under ORS 656.262(4)(f). On review, claimant contends that, because Peterson was not claimant's attending physician, and neither of claimant's other attending physicians released claimant to regular work, claimant is entitled to interim compensation for the period between April 3, 1998 through April 21, 1998. We disagree.

Here, according to the record, Dr. Davis became claimant's initial attending physician. Because he was dissatisfied with Davis's follow-up,[1] claimant self-referred to Dr. Peterson. Claimant saw Peterson on September 26, 1998 and signed a Change of Attending Physician form (form 829) naming Peterson as his attending physician. Claimant did not return to Davis thereafter.

Peterson referred claimant to Dr. Saviers for evaluation of his right shoulder condition. After receiving Saviers' diagnostic report, Peterson referred claimant to Dr. Versteeg. Claimant saw Versteeg on April 21, 1998 and signed a Change of Attending Physician form on May 4, 1998 naming Versteeg as his attending physician.

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[1] Peterson noted that, "[w]hen deferred from earlier followup, he elected to come here for evaluation." (Ex. 8; *see also* Ex. 9a-1).

On May 7, 1998, Peterson wrote to SAIF explaining that the Change of Attending Physician form 829 that he submitted was in error, and that "the visit of 3/26/98 was a consult only." (Ex. 11).

Claimant contends that Peterson retracted the Change of Attending Physician form he had filed and, therefore, was not claimant's attending physician during the period in question. We disagree.

An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b); *David A. Matthews*, 47 Van Natta 257 (1995). Whether a physician qualifies as an "attending physician" is a question of fact. *See Debbie I. Jensen*, 48 Van Natta 1235, 1236 (1996).

Here, claimant formally changed attending physicians from Davis to Peterson. In so doing, he executed a Change of Attending Physician form that specifically provided that he intended to change attending physicians. Peterson signed the form, thereby agreeing that he qualified as the attending physician. In addition, in his March 26, 1998 chart note, Peterson stated: "[Claimant] will have further treatment here following his shoulder dislocation following the report of Dr. Saviers'." (Ex. 8-1). Finally, the record shows that Peterson remained claimant's attending physician until April 21, 1998, as the other doctor (Saviers) who evaluated claimant did so at Dr. Peterson's request.

Thus, the record does not support Dr. Peterson's subsequent disclaimer that his filing of the Change of Attending Physician form was in error. In any event, under these circumstances, we conclude that, for purposes of authorizing temporary disability benefits, Dr. Peterson qualified as claimant's attending physician from March 26, 1998 to April 21, 1998. Consequently, SAIF's termination of interim compensation between April 3, 1998 and April 21, 1998 was appropriate.

ORDER

The ALJ's order dated April 21, 1999 is affirmed.

August 18, 1999 Cite as 51 Van Natta 1417 (1999)

In the Matter of the Compensation of
KIMBERLY M. NISWENDER, Claimant
WCB Case Nos. 98-08348 & 98-06145
ORDER REMANDING
Kryger, et al, Claimant Attorneys
Thomas A. Andersen, Defense Attorney
Sheridan, Bronstein, et al, Defense Attorneys

Paula Insurance Company (Paula) has requested Board review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's "new injury" claim for her left shoulder and neck condition; (2) upheld Employers Insurance of Wausau's (Wausau's) denial of the same conditions; and (3) awarded an assessed attorney fee of $4,000. The hearing was electronically recorded.

Following Paula's request for review, a transcription of the proceeding was requested. *See* ORS 656.295(3). However, the record is incomplete. A second audio tape used to record the April 14, 1999 hearing before ALJ Myzak was unintelligible. As a result, portions of claimant's testimony and most of the ALJ's comments could not be transcribed. The Board's staff counsel notified the parties' counsel and asked them to explore the possibility of reaching an agreement regarding the events/testimony given at the hearing.

Thereafter, claimant requested that the portion of the hearing that was unintelligible be reheard for the purposes of reconstructing the record. Paula "defer[s] to claimant's request, provided that the process can be accomplished expeditiously." Wausau has not responded.

In light of such circumstances, we find that the parties have been unable to reach a stipulation regarding the substance of the events and testimony that transpired at the hearing. Consequently, we have taken this matter under consideration to determine an appropriate action.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction or other necessary action. *See* ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is warranted. *See Edward R. Schofield*, 50 Van Natta 979 (1998).

Accordingly, the ALJ's May 25, 1999 order is vacated and this matter is remanded to ALJ Myzak. The ALJ shall reopen the record, and the parties shall be entitled to present testimonial evidence concerning only that portion of the hearing that was not properly recorded. That evidence may be presented in any manner that the ALJ deems achieves substantial justice. Upon presentation of the evidence and closure of the record, the ALJ shall issue a final, appealable, Order on Remand addressing the effect, if any, the evidence presented on remand has had upon the prior order.

IT IS SO ORDERED.

August 18, 1999 Cite as 51 Van Natta 1418 (1999)

In the Matter of the Compensation of
GUY R. STRAHON, Claimant
WCB Case Nos. 98-08112, 98-06860, 98-06183 & 98-02190
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock and Phillips Polich.

Liberty Northwest Insurance Company, on behalf of Baugh Construction Oregon (Liberty/Baugh), requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its responsibility denial of claimant's current carpal tunnel syndrome; (2) upheld the SAIF Corporation's responsibility denial, on behalf of McKenzie Commercial Contractors (SAIF/McKenzie), of the same condition; (3) upheld Liberty Northwest's responsibility denial, on behalf of McKenzie (Liberty/McKenzie), for the same condition; and (4) upheld SAIF's responsibility denial, on behalf of Gale M. Roberts Co., Inc. (SAIF/Roberts), for the same condition. On review, the issue is responsibility.

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

We begin with a brief summary of the ALJ's findings of fact for ease of reference. Claimant has worked as a union carpenter for a number of Oregon employers since 1978. His work entails intensive use of his dominant right arm and hand.

In 1985, claimant first developed mild right CTS symptoms. Over the years, these symptoms progressed, waxing and waning with activity. From June 28, 1994 through January 20, 1995, claimant worked for Liberty/Baugh. On August 24, 1994, claimant first sought treatment for his right CTS symptoms from Dr. Koester, family physician. Koester prescribed medication and a wrist splint; claimant's symptoms improved.

From April 1, 1996 through January 31, 1997, claimant worked for SAIF/McKenzie. In December 1996, claimant again sought treatment for his right CTS from Dr. Koester. Koester injected claimant's right wrist and his symptoms briefly improved.

From December 8, 1997 through February 4, 1998, claimant was employed by SAIF/Roberts. On December 31, 1997, claimant again sought treatment for his right CTS complaints. Dr. Mohler found a positive Phalen's test and January 1998 nerve conduction studies revealed severe right carpal tunnel syndrome (CTS). Dr. Lynch repeated the findings on January 26, 1998, and injected claimant's right wrist.

From February 12, 1998 through March 27, 1998, claimant worked for Liberty/McKenzie. The work was more strenuous than claimant's usual carpentry work. On February 25, 1998, claimant's symptoms began to worsen. On April 13, 1998, Dr. Lynch found positive Tinel's and Phalen's, and, on April 16, 1998, she performed right carpal tunnel release surgery.

Claimant's work for multiple employers and insurers since 1978 is the major contributing cause of his right CTS. Each of the above employers denied responsibility. No ".307" order issued in this case.

Applying the last injurious exposure rule (LIER), the ALJ assigned responsibility for claimant's right carpal tunnel syndrome (CTS) to Liberty/Baugh. On review, Liberty/Baugh agrees that it is initially responsible for claimant's condition under LIER.[1] But Liberty/Baugh asserts that responsibility should shift forward to Liberty/McKenzie because claimant's CTS pathologically worsened during his employment there.

To assert the last injurious exposure rule of assignment as a defense, Liberty/Baugh must prove both that claimant's underlying disease has worsened and that his subsequent employment caused the worsened condition; a mere increase in symptoms is not sufficient. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244 (1984). Liberty/Baugh has failed to show that claimant's underlying carpal tunnel syndrome worsened during his Liberty/McKenzie employment.

Dr. Lynch initially reported that a worsening of symptoms may or may not reflect a worsening of the CTS condition, and, because there were no comparative nerve conduction studies performed, she could not rely on the one report in 1998 to establish a worsened condition during the period she treated claimant, which included the period he was employed by Liberty/McKenzie. Upon further questioning, Lynch stated that, while claimant's CTS *symptoms* worsened after January 26, 1998, there was no objective worsening of his condition after that date. Lynch also stated that claimant's symptoms changed/became aggravated, and that, therefore, the "syndrome" worsened. (Ex. 36).

We conclude from Lynch's opinions that she did not equate the worsened symptoms with the underlying disease itself, and a symptomatic worsening is insufficient to shift responsibility to a subsequent employer. *E.g., Spurlock v. International Paper Co.*, 89 Or App 461 (1988).

Dr. Buehler, who also distinguished between electrophysiologic slowing of the median nerve and clinical CTS symptoms, stated: "[T]here is a pathological worsening in [claimant's] condition between 1994 and 1997 *if* you define his condition as being *symptoms* of carpel tunnel syndrome. *If* you define his condition as electrophysiological slowing, then there is no documentation of worsening." (Emphasis added). Buehler did not commit to one or the other of the definitions he provided.

Buehler further stated that there was no evidence of objective pathologic worsening between 1985 and 1997, noting that carpal tunnel syndrome is a clinical diagnosis, and that carpal tunnel syndrome and median nerve slowing are not synonymous. However, because Buehler did not endorse either of the definitions of the "condition," his opinion is equivocal and insufficient to shift responsibility from Liberty/Baugh.

This record establishes only that claimant's work subsequent to 1994 was the type of work which could cause or aggravate carpal tunnel syndrome, *i.e.*, symptoms. That is insufficient to shift the assignment of liability to Liberty/McKenzie. *Bracke v. Baza'r*, 293 Or 239, 250 (1982) (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 requests an attorney fee for his counsel's services on review. The ALJ awarded a fee of $1,000 under ORS 656.308(2)(d) for claimant's services at hearing on the responsibility issue. The 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. *Liberty Northwest Ins. Corp. v. Gordineer*, 150 Or App 136 (1997). Claimant does not assert extraordinary circumstances and we find none. Therefore, claimant is not entitled to an attorney fee for his counsel's services on review regarding the responsibility issue.

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[1] August 24, 1994, the date of first medical treatment is determinative for assigning initial responsibility for the claim. *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994).

ORDER

The ALJ's order dated December 31, 1998 is affirmed.

Board Member Phillips Polich dissenting.

The majority rejects Liberty/Baugh's argument that claimant's employment when Liberty/McKenzie was on the risk caused a worsening of claimant's right carpal tunnel syndrome. Because I disagree with the majority's interpretation of the medical evidence, I respectfully dissent.

In this case, the claim is for carpal tunnel syndrome, *not* median nerve slowing. Both the treating physician, Dr. Lynch, and the examining physician, Dr. Buehler, drew a distinction between median nerve slowing and the *syndrome* called carpal tunnel syndrome. Buehler stated: "Carpal tunnel syndrome is not the same as slowing of nerve conduction velocity or motor latencies or sensory latencies. Carpal tunnel syndrome is a clinical diagnosis, and you can have carpal tunnel syndrome with normal electrophysiologic studies * * * carpal tunnel syndrome and median nerve slowing are not synonymous." (Ex. 33-2). Lynch implicitly adopted the same analysis when she stated: [Claimant's] examination did not change/worsen objectively in my treatment period, but his symptoms changed/became aggravated [after 1994]. Therefore the "syndrome" "worsened." (Ex. 36-2). Lynch explained that, although she did not have "objective" evidence of change because the only series of electrical studies was made after 1994, there was substantial clinical and symptomatic comparison of progressive worsening to the point that claimant agreed to surgery while working for Liberty/McKenzie. Thus, the persuasive medical record establishes the distinction between the pathology of "median nerve slowing" and the *syndrome* called carpal tunnel syndrome.

Moreover, Buhler opined: [T]here is pathologic worsening in his condition between 1994 and 1997 if you define his condition as being symptoms of carpal tunnel syndrome. If you define his condition as electrophysiologic slowing then there is no *documentation* of slowing. (Ex. 33-3; emphasis added). Buhler's opinion is further supported by Lynch's opinion, discussed above. (Ex. 36-2). Because of this distinction, I would find that claimant's carpal tunnel syndrome pathologically worsened. Moreover, because claimant's claim is not for electrophysiologic slowing, but is for the carpal tunnel *syndrome*, and the syndrome pathologically worsened to the point that claimant could not continue to work, Liberty/Baugh has shown that responsibility should shift forward to subsequent employers, ending with McKenzie/Liberty.

In the Matter of the Compensation of
CYNTHIA J. THIESFELD, Claimant
WCB Case Nos. 99-00054 & 98-07403
ORDER DENYING RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Wallace, Klor & Mann PC, Defense Attorneys

Claimant requests reconsideration of our July 14, 1999 Order on Reconsideration that declined to increase the $1,000 attorney fee awarded to her counsel in the Order on Review for services at hearing and on review for prevailing over the insurer's "de facto" and formal denial of her claimed right shoulder conditions. But because we find that our prior order has become final, we lack authority to reconsider the Order on Reconsideration.

A Board order is final unless, within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. *International Paper Co. v. Wright*, 80 Or App 444 (1986); *Fischer v. SAIF*, 76 Or App 656, 659 (1986).

Here, in our July 14, 1999 Order on Reconsideration, we withdrew our June 17, 1999 Order on Review. We then adhered to and republished the order as supplemented. We also stated that the parties' rights of appeal shall begin to run from the date of the Order on Reconsideration.

The 30th day following the July 14, 1999 Order on Reconsideration was August 13, 1999. Although claimant hand-delivered her second request for reconsideration to the Board's Eugene Hearings office on August 13, 1999, the motion was not brought to our attention until August 17, 1999. Thus, before we could respond to claimant's motion, the 30-day period of ORS 656.295(8) had expired. Because the July 14, 1999 order has not been stayed, withdrawn, modified, or appealed within 30 days of its mailing to the parties, we are without authority to alter our prior decision. *See* ORS 656.295(8); *International Paper Co. v. Wright*, 80 Or App 444; *Fischer v. SAIF*, 76 Or App at 659. *See also Barbara J. Cuniff*, 48 Van Natta 1032 (1996) (although motion was hand-delivered to the Board's Portland office on the 30th day, the statutory period had expired by the time the motion was brought to the Board's attention).

As we have noted on prior occasions, the Board attempts to respond to motions for reconsideration as expeditiously as possible. *See Connie A. Martin*, 42 Van Natta 495, *recon den* 42 Van Natta 853 (1990). Notwithstanding these stated intentions, the ultimate responsibility for preserving a party's rights of appeal must rest with the party. *Id.*

Here, because claimant's second motion for reconsideration was not brought to our attention within the statutory 30-day period, we lack the authority to consider claimant's second motion for reconsideration. Accordingly, claimant's motion for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES R. TIFT, Claimant
WCB Case No. 98-09904
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's denial of claimant's claim for a low back injury. On review, the issue is compensability.

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

The ALJ found that the medical evidence was insufficient to prove compensability. We agree.

The medical evidence persuasively establishes that claimant has a degenerative condition in his low back that preexisted and combined with his September 4, 1998 low back injury. Therefore, claimant must prove that the September 1998 low back injury is the major contributing cause of his combined condition or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Claimant has the burden to prove compensability. ORS 656.266.

The only doctor to provide an opinion in support of claimant's claim is his attending neurosurgeon, Dr. Soldavilla. We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

Dr. Soldavilla opined that the major contributing cause of claimant's disability and need for treatment, including surgery, was his work activity of loading heavy boxes onto a truck on September 4, 1998. He also opined that claimant's previous back injury, including his previous surgery, made a minimal contribution to his current condition. However, as discussed by the ALJ, Soldavilla's opinion offers no reasoning for his conclusions and fails to discuss the relative contribution of claimant's degenerative changes at L4-5 and L5-S1. (Ex. 105, 106). Therefore, we agree with the ALJ that Soldavilla's opinion is insufficient to establish compensability of claimant's injury claim. *Somers v. SAIF*, 77 Or App 259 (1986) (we give most weight to opinions that are both well-reasoned and based on complete information).

ORDER

The ALJ's order dated April 7, 1999 is affirmed.

August 18, 1999 Cite as 51 Van Natta 1422 (1999)

In the Matter of the Compensation of
ROSE E. VENETUCCI, Claimant
WCB Case No. 96-04416
ORDER ON REMAND
Andrew H. Josephson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Venetucci v. Metro*, 155 Or App 559 (1998). The court has reversed our order that affirmed the Administrative Law Judge's dismissal of claimant's request for hearing regarding her objection to the SAIF Corporation's offset of allegedly overpaid temporary disability against her permanent disability award (as granted by a Notice of Closure). Concluding that claimant should have been allowed to proceed to a hearing regarding the merits of the dispute, the court has reversed and remanded.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We first briefly recount the procedural history of the case. Claimant, employed through a union hall call board, suffered a compensable heel injury. SAIF originally calculated claimant's average weekly wage at $515 and paid temporary disability based on that amount from August 25, 1993 through December 15, 1993. On May 18, 1994, SAIF sent claimant a Notice of Closure. That notice provided that the deduction of overpaid temporary disability, if any, from unpaid permanent disability was approved. Claimant was not awarded permanent disability in the Notice of Closure.

On June 16, 1994, a SAIF audit asserted that claimant's modified weekly wage rate was $374 and that SAIF had made an overpayment of $2,392.05. SAIF mailed claimant notice of this alleged overpayment the next day, indicating that it would offset off the overpayment against any future awards of permanent disability.

On claimant's motion for reconsideration, the Department rescinded the May 18, 1994 closure as prematurely issued. SAIF issued a second Notice of Closure on October 30, 1995. It provided an award of 5 percent ($2,237.02) scheduled permanent partial disability. That closure notice contained the same general language as the first regarding overpayment and offset. Nothing in the second notice, however, referred specifically to an actual overpayment.

On November 28, 1995, SAIF advised claimant by letter that the alleged overpayment was being deducted from her award for permanent partial disability and that the net payable award was zero. Claimant did not request reconsideration of the second Notice of Closure, but instead sought a hearing, contesting SAIF's amended calculation of her weekly income and alleged overpayment and seeking penalties.

SAIF moved to dismiss the request for hearing based on ORS 656.268(4)(e), which provides that, if a worker objects to the notice of closure, the worker first must request reconsideration by the department within 60 days of the date of the notice of closure. SAIF argued that claimant's objection was to the second notice of closure and that, having failed to seek reconsideration of that notice, she was prohibited from proceeding directly to hearing. The ALJ agreed, relying on *William T. Masters*, 48 Van Natta 1788 (1997). We adopted and affirmed the ALJ's order. Claimant sought judicial review.

The court reversed and remanded, reasoning that, for the mandatory reconsideration pursuant to ORS 656.268(4)(e) to preclude further review, a claimant must have an objection that is manifest in the Notice of Closure. Concluding that claimant's objection to the offset arose from her receipt of SAIF's letter announcing its intent to withhold payment of permanent disability, the court determined that SAIF's intent to withhold claimant's permanent disability award was not manifest from the Notice of Closure. *Venetucci v. Metro*, 155 Or App at 564.

In light of the court's decision, we must now determine the underlying issues in this case, which are whether SAIF correctly calculated claimant's wage rate for purposes of paying temporary partial disability and properly asserted an overpayment against the award of scheduled permanent disability. We now proceed with our analysis of those issues.

SAIF initially calculated claimant's temporary disability rate of $510 based on an hourly rate of $12.75 and the assumption of a five-day per week, 40 hour per week schedule. At the time of the May 18, 1994 claim closure, SAIF audited the file and recalculated the average weekly wage when it noticed that, on the form 801, claimant was listed as a part-time on-call worker. Applying *former* OAR 436-60-025(5)(a), SAIF determined that claimant' weekly wage should be $374 based on the average of her actual earnings. The recalculation resulted in the alleged overpayment of $2,392.05.

Although the ALJ did not reach the merits of the claim processing and penalty issues because of his determination of the procedural issue, the ALJ stated that he would have held that the recalculation of temporary disability was improper, reinstated the permanent disability award, and assessed penalties. Based on our review of the substantive issues, we reach similar conclusions.

Claimant argues that the proper rule to apply in calculating the temporary disability rate of a union hall call board employee is contained in *former* OAR 436-60-025(2)(c). That rule provided:

> "For workers employed through union hall call board insurers shall compute the rate of compensation on the basis of a five-day work week, regardless of the number of days actually worked per week."

SAIF does not dispute that the above rule would normally apply to workers such as claimant who are employed through the union hall call board. SAIF argues, however, that, for the rule to apply, claimant must prove that she was available for full-time work through the union hall call board. SAIF contends that claimant failed to prove availability for full-time work and that, therefore, *former* OAR 436-60-025(2)(c) does not apply. Accordingly, SAIF alleges that it properly used the averaging method provided in *former* OAR 436-60-025(5)(a). We disagree with SAIF's contention that the record does not establish that claimant was available for full-time work.

Although SAIF correctly observes that claimant did not testify that she was available for full-time work when injured, payroll records for the period prior to the compensable injury were entered into evidence. They show that, while claimant's hours varied, she did on occasion work in excess of 40 hours per week. (Ex. 18). From this evidence, we find that claimant was available for full-time work through the union hall call board. Further, because SAIF does not dispute that a claimant who was available for full-time work through the union hall call board should have his or her temporary disability calculated according to the union hall call board rule, we conclude that SAIF improperly reduced claimant temporary disability rate from $510 to $374. Therefore, it erroneously asserted a $2,392.05 overpayment. Because no such "overpayment" truly existed, it follows that SAIF should have paid claimant the entire amount of the permanent disability awarded in the October 1995 closure notice.[1]

We now proceed to a determination of whether SAIF's claim processing was unreasonable when it recalculated the temporary disability rate, asserted an overpayment and declined to pay claimant's permanent disability award. For the following reasons, we conclude that it was unreasonable.

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[1] SAIF asserts that, should we determine that it improperly reduced claimant's temporary disability rate, we should not order the payment of claimant's permanent disability award. SAIF argues that payment of the permanent disability award is a claim processing matter that should not be decided in this forum. It contends that claimant may still not be entitled to the entire permanent disability award because of the fact that she earned wages while receiving temporary disability. Thus, according to SAIF, claimant may have still been overpaid even at the higher temporary disability rate. We decline SAIF's request to further delay payment of claimant's scheduled permanent disability award. Claimant's request for hearing arose out of SAIF's failure to pay her the 5 percent scheduled permanent disability award. Inasmuch as we have determined that the basis for SAIF's alleged overpayment was unfounded, if follows that SAIF's decision not to pay the permanent disability award was erroneous. SAIF's reference to an additional ground for challenging payment of the permanent disability award is essentially an attempt to raise a new issue and further develop the record. The appropriate time for this was at hearing, not 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). Moreover, under these circumstances (particularly considering SAIF's belated additional challenge), we find no compelling reason to remand for further development of the record regarding the offset issue. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

A penalty can be assessed under ORS 656.262(11)(a) if the carrier's failure to pay benefits was unreasonable. Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988).

Here, SAIF's auditor testified that her recalculation was triggered by the notation on the form 801 indicating that claimant was a part-time worker. (Tr. 18). The auditor also testified, however, that she had available to her the information contained in exhibit 18, which we have held establishes that claimant was available for full time work as a union call board employee. (Tr. 31). Because application of OAR 436-60-025(2)(c) to a union call board worker is clear for the language of the rule, and SAIF was aware at the time of its audit that this was a union call board claim (Tr. 23), we find that SAIF did not have a "legitimate doubt" regarding its liability for payment of benefits. Therefore, we hold that SAIF's recalculation of the temporary disability rate (as well as its assertion of an overpayment and failure to pay the full permanent disability award) was unreasonable. Thus, we conclude that claimant is entitled to a 25 percent penalty on all amounts due under ORS 656.262(11), *i.e.*, the "withheld" 5 percent scheduled permanent disability award.

In addition, because we have ordered payment of the scheduled permanent disability awarded by the Notice of Closure, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the 5 percent "withheld" scheduled permanent disability award), not to exceed $3,800, payable directly to claimant's counsel. *See* ORS 656.386(2); OAR 438-015-0055(1).

Accordingly, on remand, the ALJ's order dated November 22, 1996 is reversed and claimant's request for hearing is reinstated. Claimant's temporary disability rate is to be based on an average weekly wage of $510. SAIF is ordered to pay claimant's 5 percent scheduled permanent disability award. SAIF shall pay pay 25 percent of the increased compensation created by this order (the 5 percent "withheld" permanent disability award), not to exceed $3,800, directly to claimant's counsel. Claimant shall also pay a 25 percent penalty based on the amount of the "withheld" permanent disability, one-half of the penalty to be paid to claimant's attorney and one-half to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM M. WHITFIELD, Claimant
WCB Case No. 99-00858
ORDER ON REVIEW
Heiling & Associates, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the insurer's denial of his aggravation claim for a right great toe fracture condition; and (2) upheld the insurer's partial denial of his claim for a right great toe neuritis condition. On review, the issues are compensability and aggravation.

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

On March 3, 1998, claimant's right great toe was fractured when a front end loader bucket was lowered onto his foot. The insurer accepted this injury as a disabling fracture of the right great toe distal phalanx. (Ex. 3). On June 23, 1998, the insurer closed the claim by a Notice of Closure that declared claimant medically stationary as of June 1, 1998, and awarded only temporary disability. (Ex. 4). Claimant requested reconsideration, raising the issues of premature closure and extent of permanent disability. On September 22, 1998, an Order on Reconsideration issued that affirmed the June 23, 1998 Notice of Closure in all respects. (Ex. 10). Claimant requested a hearing, raising the same issues of premature closure and extent of permanent disability. By order dated January 27, 1999, a prior ALJ affirmed the September 22, 1998 Order on Reconsideration in all respects. Claimant requested Board review, again raising the issues of premature closure and extent of permanent disability.

We take administrative notice of our June 22, 1999 order that adopted and affirmed the ALJ's order, with Board Member Biehl dissenting. In doing so, we note that we may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." *Rodney J. Thurman*, 44 Van Natta 1572 (1992). This includes agency orders. *See Groshong v. Montgomery Ward Co.*, 73 Or App 403 (1985); *Jenetta L. Gans*, 41 Van Natta 1791 (1989); *Susan K. Teeters*, 40 Van Natta 1115 (1988). We also note that our June 22, 1999 order has become final by operation of law.

Compensability of Aggravation Claim

On review, claimant argues that compensability of the aggravation claim for his right great toe fracture condition is established by the court created doctrine of "issue preclusion." Specifically, claimant contends that, because it has been finally determined that the June 23, 1998 Notice of Closure was correct, *i.e.*, his right great toe condition was medically stationary as of June 1, 1999, and without impairment, and his "condition now is objectively worse than being 'medically stationary without impairment,'" "issue preclusion" establishes that his aggravation claim is compensable. We disagree.

Contrary to claimant's argument, "issue preclusion" does not, in and of itself, establish compensability. Instead, "issue preclusion" precludes future litigation of issues that were "actually litigated and determined" in a setting where "its determination was essential" to the final decision reached. *Drews v. EBI Companies*, 310 Or 134, 139 (1990). In other words, if compensability had previously been at issue, litigated, and a final decision reached, "issue preclusion" would prevent that compensability issue from being litigated again. Thus, the previously litigated compensability issue would remain undisturbed. But "issue preclusion" would not independently establish "compensability" or any other issue. Furthermore, issue preclusion simply does not apply under the facts of this case.

Here, the following issues were "actually litigated and determined" in the litigation that culminated in our June 22, 1999 order: (1) whether claimant's claim was prematurely closed by the June 23, 1998 Notice of Closure; and (2) if not, whether claimant was entitled to any permanent disability regarding his right great toe injury. Neither of those issues is now being litigated. Instead, the issues before us are: (1) whether claimant sustained a compensable aggravation of his right great toe injury, *i.e.*, whether, after the last award or arrangement of compensation, claimant's condition worsened as defined in ORS 656.273;[1] and (2) whether claimant's claim for a right great toe neuritis condition is compensable. These issues regarding compensability are not precluded or decided by prior litigation regarding issues of premature closure and extent of disability. Thus, the doctrine of "issue preclusion" does not help claimant. Instead, claimant must prove the compensability of his aggravation claim and his neuritis condition claim. We agree with the ALJ that claimant failed to meet his burden of proof.

ORDER

The ALJ's order dated May 4, 1999 is affirmed.

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[1] 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. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

Board Member Phillips Polich specially concurring.

As noted above, we have taken administrative notice of the Board's June 22, 1999 order that adopted and affirmed the ALJ's order, which determined that claimant's claim was not prematurely closed and he was not entitled to any permanent disability for his right great toe injury. Board Member Biehl dissented in that order, explaining why he would have found that claimant's claim *was* prematurely closed. I find Member Biehl's dissent compelling and, on a clean slate, would find that claimant's condition was not medically stationary at claim closure. Nevertheless, as explained above, the premature closure issue is not before us. More importantly, the June 22, 1999 order has become final by operation of law. Therefore, I am bound by that decision. That said, I concur with the rationale and outcome in the present case.

In the Matter of the Compensation of
CORRINE L. BIRRER, Claimant
Own Motion No. 98-0279M
OWN MOTION ORDER
Schneider, et al, Claimant Attorneys
Argonaut Insurance Co., Insurance Carrier

The insurer initially submitted a request for temporary disability compensation for claimant's compensable bilateral knee condition. Claimant's aggravation rights expired on March 27, 1986. The insurer opposed reopening on the grounds that: (1) it was not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability. In addition, the insurer denied the compensability of claimant's current right knee condition. Claimant requested a hearing with the Hearings Division. (WCB Case No. 98-05539).

On August 26, 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 her condition worsened.

On June 21, 1999, Administrative Law Judge (ALJ) Thye issued an Opinion and Order which set aside the insurer's denial. In doing so, ALJ Thye found that claimant's current condition was causally related to the May 1980 compensable injury.

Furthermore, ALJ Thye found that claimant was in the work force at the time her condition worsened. ALJ Thye reasoned that, although not employed at the time of her disability, claimant was willing and able to and did search for work. This was demonstrated by her receipt of unemployment benefits.[1] In light of the causal relationship between claimant's compensable injury and her surgery and the aforementioned "work force" record, ALJ Thye recommended that we reopen the claim pursuant to ORS 656.278(1)(a).

The insurer requested Board review of ALJ Thye' order. However, by letter dated August 9, 1999, the insurer withdrew its request for review. In response to the insurer's withdrawal, the Board has issued an Order of Dismissal. Under such circumstances, we proceed with our review of claimant's Own Motion request.

Based on ALJ Thye's order, we conclude that claimant's current condition is related to her compensable 1980 injury claim. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

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 September 1, 1998, claimant underwent a total knee replacement. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. Furthermore, based on the record and the ALJ's uncontested recommendation, we further find that claimant was in the work force at the time of her disability.

Accordingly, we authorize the reopening of claimant's 1980 injury claim to provide temporary disability compensation beginning September 1, 1998, the date claimant was hospitalized. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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[1] We have previously found that receipt of unemployment benefits establishes *prima facie* evidence that the claimant was willing to work and was making reasonable efforts to obtain employment. *See Carol L. Conaway*, 43 Van Natta 2267 (1991); *John T. Seiber*, 43 Van Natta 136 (1991).

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
ALFREDO R. HERRERA, Claimant
WCB Case Nos. 98-07437, 98-04174 & 98-01287
ORDER ON RECONSIDERATION
Daniel Snyder, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

On August 4, 1999, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) upheld Liberty Northwest Insurance Company's denial, on behalf of Anodizing, Inc., of claimant's "new injury" claim for a thoracic strain; and (2) upheld Liberty's denial, on behalf of Waddles Restaurant, of claimant's aggravation claim for his back condition. As a procedural matter, we denied Liberty/Waddles' motion to dismiss the request for Board review. Submitting correspondence between claimant's counsel and Liberty/Anodizing's counsel, as well as a report from an official for Liberty's Claims Department concerning "multiple employer" claims, Liberty/Waddles seeks reconsideration of its dismissal motion.

Relying on ORS 656.295(2), Liberty/Waddles reiterates its prior contention that claimant's request for Board review was defective because he neglected to mail a copy to Waddles. Moreover, asserting that claimant's counsel was aware that the attorney who represented Liberty/Anodizing was not representing Liberty/Waddles, Liberty/Waddles contends that service of claimant's request for Board review on Liberty/Anodizing's counsel "would not apprise Waddles of that request." On this latter point, Liberty/Waddles seeks to distinguish *Nollen v. SAIF*, 23 Or App 420 (1995) (the holding on which we relied in our previous decision) on the basis that in *Nollen* the "un-served" employer and the "served" insurer were represented by the same attorney, while in this case, each employer/insurer was represented by a separate attorney.

Liberty/Waddles accurately cites the statutory requirement in ORS 656.295(2) that requests for Board review be mailed to "all parties." Likewise, Liberty/Waddles correctly notes that the same attorney represented the "un-served" employer and "served" insurer in *Nollen*. Nonetheless, the determinative issue for purposes of our retaining appellate review authority is not whether claimant failed to fully comply with statutory and administrative regulations (as well as reminders from Liberty/Anodizing's counsel). Rather, the pivotal question is whether these omissions preclude us from proceeding with our appellate review authority function. The resolution of that question is contained in the *Nollen* holding. After examining the applicable statute and the underlying facts, the *Nollen* court held that, in the absence of prejudice to the "un-served" employer, service on the employer's insurer was sufficient compliance with ORS 656.295(2) to vest appellate jurisdiction with the Board. *Nollen*, 23 Or App at 423-24.

The same reasoning is applicable here. Consistent with the *Nollen* holding, because Liberty/Waddles does not claim prejudice in responding to the issues arising from claimant's incomplete request for review (nor does the record support such a conclusion), we are compelled to rule that claimant's timely service of a copy of his appeal on Liberty was sufficient compliance with ORS 656.295(2) for the Board to retain appellate jurisdiction to proceed with its review.[1]

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[1] We note that claimant's request for Board review indicates that a copy was mailed to Liberty and Anodizing on November 25, 1998 (which was within 30 days of the ALJ's October 30, 1998 order). As we reasoned in our prior decision (note 6), considering Liberty's dual capacity as insurer for both employers, claimant's timely service on Liberty establishes timely actual notice of his appeal on each of its insureds (in the absence of prejudice to an "unserved" employer). Likewise, claimant's failure to serve a copy of his appeal on Liberty/Waddles' counsel (in violation of OAR 438-011-0005(2) does not deprive this forum from its appellate review authority. *Charlotte M. Soros*, 50 Van Natta 2072, *on recon* 50 Van Natta 2233 (1998).

In reaching this conclusion, we distinguish the two decisions cited by Liberty/Waddles. In *Mosley v. Sacred Heart Hospital*, 113 Or App 234 (1992), as well as in *Lanny W. Lacey*, 51 Van Natta 868 (1999), a claimant's request for Board review was found defective pursuant to ORS 656.295(2). However, in both decisions, neither the employer nor its insurer had been mailed a copy of the claimant's request for review. Here, in contrast, the insurer for an "unserved" employer was timely mailed a copy of claimant's request for Board review. Under such circumstances, the *Mosley* holding is not applicable and the *Nollen* rationale is controlling.

Finally, submitting reports and materials detailing its efforts to "prevent conflict of interest" and "confidentiality" in "multiple employer" claims, Liberty/Waddles expresses concern regarding the potential logistical and ethical problems arising from our decision. Our denial of the dismissal motion should not be interpreted by future appealing parties as permission to ignore statutory and administrative requirements regarding the timely service of requests for Board review on all parties to the proceeding.[2] *See* ORS 656.295(2); OAR 438-011-0005(2). To the contrary, we presume that appealing parties will continue to follow their respective legal obligations.

Our decision is solely confined to the question of whether a party's failure to fully comply with the service requirements of ORS 656.295(2) prevents us from conducting our appellate review of an ALJ's order. The answer to that question has been provided by the *Nollen* court. Should a case arise when an appealing party neglects to serve an employer, the timely service of the request for Board review on its insurer (in the absence of prejudice to the employer) will be sufficient under the *Nollen* interpretation of the statutory scheme to vest appellate jurisdiction with the Board. Barring a reversal of the *Nollen* decision or a statutory amendment, we are without authority to hold otherwise.

Accordingly, our August 4, 1999 order is withdrawn. On reconsideration, as supplemented, we republish our August 4, 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] Likewise, our conclusion should not be interpreted as an indication that this insurer (or any other carrier) should revise its internal claim processing procedures. Consistent with the statutory and administrative regulations cited above, our decision is not intended to dispute the fundamental proposition that the responsibility for providing notice of appeals rests with the appealing party. Rather than commenting on any carrier's internal procedures, the sole message intended from our decision can be succinctly summarized as follows: In the absence of prejudice to an employer, the timely service by mail of a copy of a claimant's request for review on the employer's insurer is sufficient compliance with ORS 656.295(2) to bestow appellate jurisdiction with the Board.

Board Member Haynes dissenting.

For the reasons expressed in my prior dissenting opinion, I agree with Liberty/Waddles that claimant's request for Board review was defective and should be dismissed. Consequently, I would continue to grant the motion to dismiss.

In the Matter of the Compensation of
ROCKY M. ADAMS, Claimant
WCB Case Nos. 98-07784, 98-07776 & 98-04882
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's injury claim for his L5-S1 disc condition. Claimant cross-requests review of that portion of the ALJ's order that declined to award a penalty for allegedly unreasonable claims processing. On review, the issues are compensability and penalties and attorney fees.

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

On review, claimant contends that he is entitled to a penalty for SAIF's allegedly unreasonable failure to accept or deny the claim within 90 days. ORS 656.262(11). Claimant also argues that an attorney fee pursuant to ORS 656.382(1) is appropriate for SAIF's unreasonable claims processing. However, SAIF argues that the ALJ found that the penalty issue had been withdrawn and, therefore, the issue should not be addressed for the first time on review.

For the following reasons, we conclude that it is not necessary to address whether the penalty issue was withdrawn by claimant. At hearing, claimant conceded that all compensation had been paid by SAIF. (Tr. 14.) Accordingly, because there are no amounts due upon which to base a penalty, claimant cannot prevail on that issue. *See* ORS 656.262(11); *Spivey v. SAIF*, 79 Or App 568 (1986). Moreover, we have held that, even if a carrier does not timely accept a claim, there is no unreasonable resistance to the payment of compensation if all compensation has been paid and, therefore, no attorney fee is available under ORS 656.382(1). *Mark A. Klouda*, 51 Van Natta 265 (1999); *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993). Consequently, in this case we find no basis for a penalty or attorney fee for SAIF's untimely denials.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 18, 1999 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,750 for services on review, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
CLIFFORD D. CORNETT, Claimant
WCB Case Nos. 98-05318, 98-05317, 98-05316 & 97-10236
ORDER ON REVIEW
Phillip H. Garrow & Janet Breyer, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Reinisch, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The Travelers Insurance Company (The Travelers), on behalf of its insured, Marus Dental International, requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) assessed a penalty for the insurer's allegedly untimely denial of responsibility; and (2) awarded a $10,260 assessed fee. On review, the issues are penalties and attorney fees. We modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Attorney Fees

The Travelers contends that the ALJ's assessed attorney fee award of $10,260 is excessive. For the following reasons, we agree.

We determine the amount of claimant's counsel's attorney fee for services at the hearing by applying the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The issues in dispute were the compensability of and responsibility for claimant's bilateral shoulder condition. Three out of the four carriers, however, conceded compensability. (Tr. 5). The Travelers was the only carrier that contested compensability. Moreover, counsel for the Travelers stated for the record that the compensability issue "[would] not be strenuously pursued." (Tr. 5).

Approximately 50 exhibits were received into evidence, one of which was generated by claimant's counsel and did pertain to compensability. (Ex. 33). Two lengthy depositions took place. (Exs. 49, 50). However, at one deposition (Dr. Jacobson's), claimant's counsel asked no questions. (Ex. 50-86). At the other, only a small portion of the questioning of Dr. McKillop was done by counsel for the Travelers. (Ex. 49). Eight pages of the 54 page transcript contained questioning by claimant's counsel. (Ex. 49: p. 42-50). The hearing lasted two and one-half hours and the transcript consists of 89 pages. Claimant was the only witness. Although claimant was subjected to extensive cross-examination, much of it was conducted by counsel for carriers that had conceded compensability. In his statement of services, claimant's counsel indicated that he spent 34.2 hours on this case.[1]

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[1] Claimant notes that no party objected to his statement of services at hearing. Claimant, therefore, 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), *Aff'd Hays v. Tillamook County General Hospital*, 160 or App 55 (1999), 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 the Travelers can challenge the attorney fee award on review.

The compensability issue primarily involved an evaluation of medical evidence and was of a complexity level that is normally faced by the Board and its Hearings Division. Because claimant's bilateral shoulder condition has been found compensable, claimant is entitled to further workers' compensation benefits. The parties' attorneys were skilled and presented their positions in a thorough, well-reasoned manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical evidence, there was a risk that claimant's counsel's efforts might go uncompensated. Considering all these factors, we find that $4,000 is a reasonable fee for claimant's counsel's services at the hearing level concerning compensability of the bilateral shoulder condition under ORS 656.386(1).[2] The ALJ's order is modified accordingly.

Under ORS 656.308(2)(d), claimant's counsel was entitled to an attorney fee for services at hearing for finally prevailing over the Travelers' responsibility denial.[3] 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, payable by the Travelers. *See Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155, 158 (1997). 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).

Penalties

The ALJ assessed a penalty under ORS 656.262(11)(a) based on the Travelers' untimely denial of responsibility. On review, the Travelers does not contest the ALJ's finding that the Travelers' responsibility denial was untimely. The Travelers nevertheless contends that claimant did not raise the penalty issue because, at hearing, claimant's counsel specifically stated that he was only raising the issues of compensability and responsibility. (Tr. 5).[4]

Nonetheless, claimant did not argue the issue of a penalty under ORS 656.262(11)(a) at hearing. In his March 19, 1998 supplemental request for hearing, however, claimant's attorney contended that the Travelers' responsibility denial was untimely and requested a penalty under ORS 656.262(11).

Issues raised in pleadings are generally ripe for resolution, even if they are not raised or argued at hearing. *See Liberty Northwest v. Alonzo*, 105 Or App 458, 460 (1991); *Connie G. Johnson*, 47 Van Natta 1984, 1987 (1995). We have nevertheless recognized that a party may implicitly "waive" its right to assert an issue. *See Valerie Barbeau*, 49 Van Natta 1189 (1997). In *Barbeau*, we held that an ALJ did not err in declining to address the compensability of the claimant's claim on a medical causation basis, even though the carrier, prior to hearing, had amended its denial based on untimely claim filing to contest medical causation. Specifically, we determined that the carrier implicitly waived its right to assert a medical causation defense at hearing when: (1) the carrier's attorney expressly agreed with the ALJ's statement of issues (that the basis for the denial was an untimely claim and that the only issues were timeliness and penalties and attorney fees arising from the denial); (2) the carrier's counsel did not respond to the claimant's counsel's comments that the claimant did not consent to the raising of any other issues other than issues raised by the denial; and (3) the carrier's counsel did not declare an intention to litigate medical causation/compensability issues. 49 Van Natta at 1190.

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[2] In reaching this conclusion, we note that the amount of time expended in litigating a claim is not determinative, but rather is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4). *Ben E. Conradson*, 51 Van Natta 851, n2 (1999).

[3] Although claimant prevailed against both a denial of compensability and responsibility, the ALJ did not state which portion of his award was made under ORS 656.386(1) and which part was awarded pursuant to ORS 656.308(2)(d); the latter statute limits attorney fees in responsibility disputes to a maximum of $1,000, absent "extraordinary circumstances."

[4] The ALJ asked claimant's counsel "what other issues do I need to decided (sic) other than compensability and responsibility." Claimant's counsel replied: "Those are the only issues we've raised, your honor."

In this case, claimant did raise a penalty issue in the pleadings. But, when specifically asked by the ALJ at hearing whether there were any issues to be decided in addition to compensability and responsibility, claimant's counsel expressly stated that compensability and responsibility were the only issues raised. Considering the "totality of circumstances," we conclude that claimant waived the penalty issue. *Id.*; *See Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 688 (1995), *on remand Connie M. Johnson*, 48 Van Natta 239 (1996) (whether a "waiver" has occurred must be ascertained from the "totality of the circumstances"). Therefore, we reverse the ALJ's assessment of a penalty under ORS 656.262(11)(a).[5]

ORDER

The ALJ's order dated January 25, 1999 is modified in part, reversed in part, and affirmed in part. The ALJ's $10,260 assessed fee award is modified to award $4,000 under ORS 656.386(1) for claimant's counsel's services at hearing regarding the compensability issue, payable by The Travelers. For services at hearing regarding the responsibility issue, claimant's attorney is awarded $1,000 under ORS 656.308(2)(d), payable by The Travelers. The ALJ's assessment of a penalty is reversed. The remainder of the ALJ's order is affirmed.

[5] In reaching this conclusion, we distinguish *Alonzo*. In contrast to that case, where there was no indication that the carrier stated at hearing that only certain issues were raised, claimant's attorney in this case unambiguously stated that compensability and responsibility were the only issues when specifically asked to delineate the issues. Under these circumstances, we do not find that claimant's prior assertion of a right to a penalty in the supplemental hearing request authorized the ALJ to reach the penalty issue.

In the Matter of the Compensation of
FRED E. PARKS, Claimant
WCB Case No. 98-07779
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's injury claim for a right elbow condition. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

The ALJ set aside the employer's denial, rejecting its contention that claimant's claim was made in retaliation for a disciplinary action claimant believed was unjustified. The ALJ concluded that it was more probably true than not that claimant injured his right elbow at work on August 10, 1998.

We agree with the ALJ's reasoning. Citing *Linda S. Clemens*, 50 Van Natta 2269 (1998), the employer contends, however, that the claim should fail for lack of "objective findings." It asserts that findings of "tenderness" over the right epicondyle do not qualify as "objective findings" because they were twice made by a physician's assistant (Mr. Siniscal), whose findings, according to the employer, should be rejected because he is not a physician, and once by a medical doctor (Feldstein) who did not repeat her testing. We find *Clemens* distinguishable and reject the employer's contentions.[1]

[1] Claimant argues that the employer should not be allowed to argue the merits of the medical evidence because its counsel allegedly did not contest the medical evidence at hearing. (Tr. 6). We need not determine whether claimant's contention is correct. That is, even if the employer did not waive the "objective findings" issue at hearing, we would still find that the claim was supported by "objective findings."

A compensable injury is established by proof that claimant's work exposure was a material contributing cause of his disability or need for treatment, if the injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a); *see Mark N. Weidle*, 43 Van Natta 855 (1991). Claimant bears the burden of proving compensability. ORS 656.266.

ORS 656.005(19) provides:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

We have previously held that "tenderness" can be an objective finding when the medical evidence establishes that it is "reproducible." *See Marilyn M. Keener*, 49 Van Natta 110, 112 (1997) (finding "tenderness" to be an objective finding where reproducible). In *Clemens*, a physical therapist reported findings such as "hypermobility" and reduced range of motion. We noted, however, that the attending physician had not referred to or adopted the physical therapist's findings. Moreover, even assuming that a physical therapist's findings by themselves could constitute "objective findings," we agreed with the employer that those findings were inconsistent with the other medical evidence; *e.g.* the physical therapist had included findings that no physician reported. Accordingly, we found that the physical therapist's report did not establish the existence of "objective findings" related to the claimant's alleged injury. *Linda S. Clemens*, 50 Van Natta at 2270 n. 1.

In contrast to *Clemens*, a medical doctor (Dr. Rabie) referred to and adopted the findings of the physician's assistant, Mr. Siniscal. (Exs. 22A, 33-18). Moreover, Mr. Siniscal's findings of tenderness were consistent with the finding of tenderness made by a physician, Dr. Feldstein. (Ex. 27). Under these circumstances, we find that claimant's right elbow claim was supported by "objective findings." Therefore, we conclude that the ALJ properly determined that the right elbow claim was 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 $1,920, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the penalty issue. *Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated March 8, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,920, to be paid by the employer.

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
ORDER ON RECONSIDERATION
Donald Hooton, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Claimant requests reconsideration of our May 19, 1999 order that adopted the Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denials of claimant's injury claims for cervical and thoracic conditions. On June 18, 1999, we withdrew our order for reconsideration. In his motion for reconsideration, claimant seeks remand for the admission of additional evidence. Having received the parties' supplemental briefs, we proceed with our reconsideration.

Claimant seeks remand for the admission of additional evidence. 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).

Claimant has submitted a July 12, 1999 letter from Dr. Saxey. This letter states that Dr. Saxey is a radiologist who took x-rays of claimant's cervical spine in 1989. Claimant argues that this letter establishes that the ALJ was incorrect in stating that claimant was treated by Dr. Saxey in 1989 for cervical symptoms, including numbness and tingling of the fingers. Because we find that the letter from Dr. Saxey was not unobtainable at the time of hearing and because it is not reasonably likely to affect the outcome of the case, we decline to remand for its admission into evidence. To the extent that the ALJ's finding that claimant was treated for cervical problems in 1989 was incorrect, however, we do not adopt that finding.

Claimant submits a letter from Dr. Anderson, a physician that he saw in 1993. Again, it has not been shown by the claimant that this letter was unobtainable at the time of the hearing. Although the document is dated July 16, 1999, there is no apparent reason why a similar letter could not have been obtained at the time of hearing. In addition, the letter is unlikely to affect the outcome of the compensability issue.

Claimant also has submitted a March 24, 1995 letter to SAIF's claims adjuster complaining of errors in Dr. Anderson's report. Again, this document is not reasonably likely to affect the outcome of the dispute and does not warrant remand.

Claimant has also submitted a January 11, 1996 report from Dr. Mandiberg which the ALJ declined to admit into evidence. We previously held that this report did not warrant remand because it was unlikely to affect the outcome of the case. *Steven D. Windsor*, 48 Van Natta 876 (1996) (on recon). We adhere to our prior decision and decline to remand for admission of this report.[1]

Finally, claimant has submitted a June 13, 1995 letter from Dr. Irvine. The report is cumulative since the record already contains reports from Dr. Irvine addressing the causation issue. Accordingly, we decline to remand for admission of this letter.

With regard to the merits of the compensability issue, we continue to agree with and adopt the ALJ's opinion as our own. The persuasive medical evidence does not establish that the cervical condition was caused in major part by the January 1993 compensable injury. Dr. Mandiberg, as the physician who treated for the work injury both before and after the noncompensable motor vehicle

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[1] Claimant has also attached Dr. Mandiberg's June 3, 1996 report to his motion. We note, however, that this document is already contained in the record.

accident, is in the best position to determine causation of the cervical condition.[2] There is also some evidence that claimant may have had symptoms consistent with a preexisting cervical problem prior to the work injury although there is no evidence that this condition required treatment. Based on Dr. Mandiberg's opinion, the cervical symptoms began and were caused by the motor vehicle accident. In his most recent opinions, Dr. Mandiberg was unable to causally attribute the cervical condition to the work injury. Under such circumstances, we continue to adhere to our May 19, 1999 order adopting the ALJ's order.

As supplemented herein, we republish our May 19, 1999 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[2] As noted by the ALJ, Dr. Mandiberg's June 3, 1996 opinion was inconsistent with both his earlier and later opinions. Based on the record, including the deposition testimony of both claimant and Dr. Mandiberg (Ex. 143-6), the ALJ found that Dr. Mandiberg was "pressured" by claimant to attribute the cervical condition to the compensable injury. We have independently reviewed the record and we agree with (and have adopted) the ALJ's conclusion that the June 3, 1996 report should not be accorded any weight.

In the Matter of the Compensation of
DOUGLAS R. YARBROUGH, Claimant
WCB Case No. 99-00739
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that dismissed claimant's request for hearing from a Department order denying his request for reconsideration of a Notice of Closure. Claimant requests remand to the ALJ for further development of the record and a hearing regarding his entitlement to permanent partial disability (PPD) under the notice of closure. On review, the issues are timeliness of claimant's request for reconsideration/jurisdiction, remand and PPD. We affirm.

FINDINGS OF FACT

The SAIF Corporation closed claimant's accepted injury claim with a Notice of Closure that listed September 9, 1998 as the "Date of Closure (mailing date)." (Exs. 15 and 16). This notice was addressed to claimant at his last known address, and the notice indicated that a copy was sent to claimant's counsel. On September 11, 1998, claimant's counsel withdrew his representation of claimant. (Ex. 17). Claimant's former counsel did not file a request for reconsideration from the September 9, 1998 Notice of Closure. After claimant's release from prison, he retained his present counsel and filed a December 30, 1998 request for reconsideration from the closure. (Ex. 20). On January 8, 1999, the Department issued an order denying claimant's request for reconsideration as untimely. (Ex. 22). Claimant requested a hearing from the Department's order denying the request for reconsideration.

CONCLUSIONS OF LAW AND OPINION

Claimant's request for reconsideration was untimely if it was not mailed within 60 days of the mailing date of the September 9, 1998 Notice of Closure. ORS 656.268(4)(e); OAR 436-030-0005(9) and 436-030-0115(2). At hearing, claimant argued that he had "good cause" for the alleged untimely filing of the request for reconsideration. Specifically, claimant asserted that he did not personally receive or read any of his mail from September 3 through December 30, 1998 because he was incarcerated during that period. The ALJ concluded that there was no "good cause" exception to the 60-day statutory filing period. Accordingly, the ALJ affirmed the Department order denying the request for reconsideration as untimely.

On review, claimant does not reiterate the "good cause" argument and, instead, asserts that SAIF has not carried its burden of proving that claimant's request for reconsideration was not mailed within the statutory 60-day period. Specifically, claimant argues that SAIF has not established when, or if, it mailed the notice of closure.

In support of his argument, claimant asserts that SAIF did not mail the notice of closure by certified or registered mail or otherwise provide personal service as required under OAR 438-005-0065. Claimant also notes that SAIF offered no evidence of its internal processing of the notice of closure after it was finalized. Claimant also relies on the court's analysis in *Madewell v. Salvation Army*, 49 Or App 713 (1980), and the Board's application of *Madewell* in *Rickey A. Stevens*, 49 Van Natta 1444 (1997).

We are not persuaded by claimant's argument. The requisite certified/registered mailing and/or personal service required under OAR 438-005-0065 is only applicable to requests for hearing filed with the Board. Consequently, that rule has no application in the present case involving a request for Department reconsideration of a notice of closure.

Furthermore, the present case is distinguishable from *Madewell* and *Stevens*. In *Madewell*, the court treated a request for hearing from a denial as timely because the employer had not put on any evidence that the denial was mailed on the day it was dated. *Madewell*, 149 Or App at 715-716. In so concluding, the court noted that, while there is a presumption that a writing is truly dated and that a letter directed and mailed was received in regular course of the mail, there is no presumption that a letter is mailed on the day it is dated or on the day it was written. *Id.* In *Stevens*, the Board relied on *Madewell* in concluding that the claimant had filed a timely request for hearing from a denial. *Stevens*, 49 Van Natta at 1445-1446. In so concluding, the *Stevens* Board reasoned that the insurer offered neither documentary nor testimonial evidence of the date on which its denial letter was actually mailed. *Id.*

Here, the notice of closure expressly identifies September 9, 1998 as both the date of closure and the "mailing date." Thus, unlike the situation in *Madewell* and *Stevens*, the record in the present case does include evidence that the notice of closure was mailed on September 9, 1998. Moreover, there is no contrary evidence that the notice was not, in fact, mailed on that date. On this record, we conclude that the record establishes that the notice was mailed on September 9, 1998. Consequently, we agree with the ALJ's ultimate conclusion that claimant's request for reconsideration was untimely because it was mailed more than 60 days after the notice of closure was mailed on September 9, 1998.

ORDER

The ALJ's order dated April 2, 1999 is affirmed.

In the Matter of the Compensation of
WOODROW T. BERNARD, Claimant
WCB Case Nos. 98-07556 & 98-04544
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

On July 21, 1999, we abated our July 8, 1999 order that affirmed the Administrative Law Judge's (ALJ's) order affirming that portion of an Order on Reconsideration awarding 38 percent (121.6 degrees) unscheduled permanent disability for claimant's contact dermatitis condition. We took this action to consider the self-insured employer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

Claimant has a compensable contact dermatitis that affects his neck and face. The employer challenged the ALJ's finding of 38 percent impairment under OAR 436-035-0440, asserting that, because claimant developed an "immunological reaction" to physical, chemical or biological agents, unscheduled permanent disability should be rated according to subsection (1) of that rule. That subsection provides that, in such cases, impairment is valued pursuant to OAR 436-035-0450. OAR 436-035-0450 concerns impairment of the immune system as a result of the development of an "immunological response."

The ALJ rejected the employer's argument because there was no evidence that claimant developed an immunological reaction. The employer contended, however, that we should not require medical evidence to prove that an allergic reaction is synonymous with an immunological response. The employer cited a definition of "immunology" from Dorland's Medical Dictionary (25th ed., 1980) as support for its assertion. There, "immunology" is defined as "the science of dealing with aspects of immunity, including allergy, hypersensitivity, etc."

Citing *SAIF v. Calder*, 157 Or App 224, 227 (1998), we rejected the employer's argument. We reasoned that, while we may take notice of Dorland's definition of "immunology" as a science that concerns allergies, this did not necessarily mean that an allergic reaction is synonymous with an immunological reaction. In accordance with *Calder*, we concluded that there must be medical evidence in the record that claimant experienced an "immunological reaction" to physical, chemical or biological agents in order for claimant's unscheduled impairment in the face and neck to be rated under subsection 1 of OAR 436-035-0440. Because this record lacked evidence that an allergic reaction constitutes an immunological reaction, we agreed with the ALJ that unscheduled impairment for the face and neck is rated, not under subsection 1, but rather under subsection 2. Pursuant to that subsection, we found that claimant was entitled to class III impairment (38 percent) based on the medical arbiter's (Dr. Larsen's) assessment. Thus, we affirmed that part of the ALJ's order.

The employer now contends that our decision to require medical evidence was incorrect in light of *Jerry L. Bliss*, 49 Van Natta 1133, *on recon* 49 Van Natta 1471 (1997). In that case, the carrier argued that no medical evidence established that "allergic" meant an "immunological response" or "impairment of the immune system." Therefore, the carrier argued in *Bliss* that there was insufficient evidence to conclude that OAR 436-035-0450 applied to rate the claimant's impairment due to contact dermatitis. We disagreed.

Instead, we found that the rules themselves determined that OAR 436-035-0450 applied to the claim. We noted that OAR 436-035-0110(5) provided that "[c]ontact dermatitis of an upper extremity is rated in this section unless it is an allergic systemic reaction, which is rated pursuant to former OAR 436-035-0450." We noted that the claimant had both allergic and irritant contact dermatitis. Therefore, we found that the claimant's dermatitis condition was rated under OAR 436-035-0450.

We do not find *Bliss* controlling. First, *Bliss* was decided prior to the court's decision in *Calder*. Moreover, we assumed in *Bliss*, without citing supporting medical evidence, that contact dermatitis was equivalent to an allergic systemic reaction, which is rated pursuant to OAR 436-035-0450. However, OAR 436-035-0110(5) provides that contact dermatitis of an upper extremity is rated in that section *unless it is an allergic systemic reaction*, which is rated pursuant to OAR 436-035-0450. OAR 436-035-0110(5), therefore, implies that contact dermatitis may, in some instances, not be an allergic systemic reaction and, thus, must be rated under OAR 436-035-0110(5). In light of such circumstances, contact dermatitis is not automatically rated under OAR 436-035-0450, the rule dealing with "immunological response" and impairment of the immune system.

Accordingly, we continue to conclude that medical evidence was required to establish that an allergic reaction is synonymous with an immunological response.[1] The employer contends, however, that, even if OAR 436-035-0440(2) is the proper rule for rating permanent disability, class III was an incorrect rating of claimant's impairment. We disagree.

First, we note that the employer did not challenge Dr. Larsen's rating in its briefs. In any event, we agree with the ALJ's reasons for accepting Dr. Larsen's class III rating under OAR 436-035-0440(2).

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 reconsideration is $250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response to the employer's reconsideration request), the complexity of the issue, and the value of the interest involved.

On reconsideration, as supplemented herein, we adhere to and republish our July 8, 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] The employer cites additional definitions from Dorland's Medical Dictionary 25th Edition, 1974, as support for its contention that allergic and immunological reactions are the same. We remain unpersuaded that this issue can be resolved merely through medical dictionary definitions, rather than by persuasive medical evidence.

In the Matter of the Compensation of
TYLER LARSON, Claimant
WCB Case No. C991782
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Randy Rice, Defense Attorney

Reviewed by Board Members Biehl and Bock.

On August 11, 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 July 27, 1999, we wrote the parties requesting an addendum to the CDA, clarifying the amount of consideration. In our letter, we noted that the first page of the agreement provided $3,000 to claimant and $750 to claimant's attorney, which equals a total consideration of *$3,750*. However, the body of the document provided a total consideration of *$3,000* out of which claimant's attorney would receive $750. On August 4, 1999, we received the parties' addendum, stating that the first page should be amended to provide that the total consideration due claimant is $2,275. We approved the CDA on August 11, 1999.

On August 18, 1999, we received the parties' motion for reconsideration and second addendum to the CDA, clarifying the parties' intent. The addendum indicates that the total amount of consideration due claimant is $2,250 and the total due claimant's attorney is $750.

In order to be considered, a motion for reconsideration of the approved CDA must be received by the Board within 10 days of the date of mailing of the final order. OAR 438-009-0035(1),(2). Because the request for reconsideration was received on August 18, 1999, 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 parties' second addendum, we find that the total consideration is $3,000 with claimant receiving $2,250 and claimant's attorney receiving $750. 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' addendum and this order, is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
WALTER L. FUGE, Claimant
WCB Case No. 98-03643
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Phillips Polich.

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 disc herniation at L5-S1. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The issue in this case is compensability of claimant's occupational disease claim for a disc herniation at L5-S1. The ALJ found that claimant had preexisting degenerative dise disease in his lumbar spine, including the L5-S1 level and, therefore, ORS 656.802(2)(b) applied. The ALJ relied on the opinion of claimant's treating physician, Dr. Hoppert, and concluded that the L5-S1 disc herniation was compensable.

The employer argues that Dr. Hoppert's opinion on causation is not sufficient to meet claimant's burden of proof under ORS 656.802(2)(b). On the other hand, although claimant agrees that the major contributing cause standard under ORS 656.802(2)(b) applies, he contends that he need only prove that his work activities were the major cause of the need for treatment.

Even if we assume, without deciding, that claimant need only establish that his work activities were the major cause of the need for treatment, we find that the medical evidence does not meet that standard of proof. Moreover, we agree with the employer that the medical evidence is not sufficient to meet claimant's burden of proof under ORS 656.802(2)(b).

Claimant compensably injured his low back in 1990. Dr. Hoppert performed a laminotomy and discectomy at L3-4. (Ex. 18). Claimant's current lumbar condition involves an L5-S1 disc herniation that required surgery in April 1998. (Ex. 60). He acknowledges that he has lumbar degenerative disc disease that has been in existence for 5 to 8 years. (Ex. 66). Claimant has worked for the employer since 1985. (Tr. 15).

Because of the multiple possible causes of claimant's disability or need for treatment, the causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Hoppert.

Dr. Hoppert has been treating claimant since October 1990 and he performed a L3-4 laminotomy and diskectomy in November 1990. (Exs. 8, 18). Claimant returned to Dr. Hoppert in August 1997 because of low back problems. (Ex. 43). In March 1998, claimant had increasing pain in his low back and left thigh. (Exs. 48, 63). A lumbar MRI showed a moderate-sized left disc herniation at L5-S1 with nerve root impingement, a small left disc herniation at L4-5 and scar tissue at L3-4. (Ex. 47). On April 24, 1998, Dr. Hoppert performed a left L5-S1 hemilaminatomy/diskectomy. (Ex. 60).

On July 29, 1998, Dr. Hoppert discussed the causation of claimant's current low back condition. (Ex. 62). He explained:

> "Antecedent to his most recent disk problem he had several month history of increasing low back pain which was related to his work as a truck driver. Bouncing, lurching around the inside of the truck, lifting and twisting when working around the truck had brought on the condition. Particularly aggravating was bending over to elevate a window or portion of the door. The lifting activities gave severe pain." (*Id.*)

Shortly thereafter, Dr. Hoppert wrote to claimant's attorney, stating that the etiology for claimant's current low back condition was a combination of his inherent tendency to develop lumbar spine degenerative disk disease and his work exposure. (Ex. 63-2). He felt that claimant's "work exposure is a major contributing cause for his need for treatment" and he explained that a combination of work exposure and claimant's "innate vulnerability" led to his need for care. (*Id.*)

On December 9, 1998, Dr. Hoppert responded to questions from claimant's attorney after reviewing Dr. Bald's deposition. Dr. Hoppert explained:

> "My opinion is that [claimant's] current lumbar condition was cause [sic] in a major way both by the pre-existent degenerative disk disease and by his work activities. His lumbar spine demonstrates degenerative disk disease and has done so over the past five to eight years. However, the work that he does has worsened the underlying condition, making the vulnerable condition of the lumbar spine and leading to disk herniation/rupture [sic].
>
> "The fact that he has degenerative disk disease does not automatically dispose him to lumbar surgery. I think that, as stated above, the work exposure serves as a major factor in his need for surgical care." (Ex. 66).

A determination of the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Even if we assume, without deciding, that claimant need only establish that his work activities are the major cause of the need for treatment, we find that Dr. Hoppert's opinions do not meet the requisite standard of proof.

In his August 4, 1998 report, Dr. Hoppert said that claimant's "work exposure is *a* major contributing cause for his need for treatment." (Ex. 63-2; emphasis supplied). In a December 9, 1998 report, Dr. Hoppert said that claimant's current lumbar condition was caused "in *a* major way *both* by the pre-existent degenerative disk disease and by his work activities." (Ex. 66; emphasis supplied). Later in the same report, Dr. Hoppert reiterated that claimant's "work exposure serves as *a* major factor in his need for surgical care." (*Id.*;emphasis supplied).

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. *Freightliner Corp. v. Arnold*, 142 Or App 98 (1996). Here, however, even if we assume that claimant need only establish that his work activities were the major cause of his need for treatment, we conclude that Dr. Hoppert's reports are not persuasive. His reports, when read as a whole, are not sufficient to establish that claimant's work activities were "the" major contributing cause of his L5-S1 disc herniation, particularly since he felt that the current lumbar condition was caused "in *a* major way *both* by the pre-existent degenerative disk disease and by his work activities." (Ex. 66; emphasis supplied). *See Waldtraut M. McRorie*, 51 Van Natta 368 (1999) (considering the physician's opinion as a whole, opinion that injury was "a" major contributing cause did not meet the claimant's burden of proof); *Arnold D. Schaffer*, 47 Van Natta 1667 (1995), *aff'd mem* 140 Or App 137 (1996). Moreover, Dr. Hoppert's opinion is not sufficient to establish that claimant's work activities were the major contributing cause of the combined condition *and* pathological worsening of his disease under ORS 656.802(2)(b).

The only other medical report on causation is from Drs. Bald and Ferris, who examined claimant on behalf of the employer. (Exs. 52, 53, 54). They opined that the major contributing cause of claimant's current low back condition was progressive preexisting degenerative disc disease. (Ex. 53-4). Drs. Bald and Ferris found that claimant's work activities were only a minor contributing factor in claimant's current lumbar condition. (Ex. 53-5).

ORDER

The ALJ's order dated March 18, 1999 is reversed. The employer's denial of claimant's L5-S1 disc herniation is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority rejects the ALJ's finding that claimant was a credible witness and it concludes that claimant failed to establish compensability of his L5-S1 disc herniation. For the following reasons, I respectfully dissent.

The ALJ found that claimant was credible and his determination is entitled to considerable weight. I would defer to the ALJ's credibility finding. Moreover, I agree with the ALJ's interpretation of the medical evidence. 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).

Here, there are no persuasive reasons not to defer to the opinion of Dr. Hoppert, claimant's attending physician. Dr. Hoppert reported that "the etiology for [claimant's] low back condition is a combination of his inherent tendency to develop lumbar spine degenerative disk disease and his work exposure" and he opined that claimant's work activities were the major contributing cause of his need for treatment. (Ex. 63). In a later opinion, Dr. Hoppert indicated that claimant's work had worsened the underlying condition, "making the vulnerable condition of the lumbar spine and leading to disk herniation/rupture." (Ex. 66). I agree with the ALJ that Dr. Hoppert's reports are sufficient to meet claimant's burden of proving compensability of his L5-S1 disc herniation.

August 25, 1999 Cite as 51 Van Natta 1441 (1999)

In the Matter of the Compensation of
CONNIE J. BARRS, Claimant
WCB Case No. 98-04851
ORDER OF ABATEMENT
Edward J. Harri, Claimant Attorney
Schwabe, et al, Defense Attorneys
Kryger, et al, Attorneys

Claimant has requested reconsideration of our July 30, 1999 Order on Review. Specifically, claimant contends that we erred in reversing those portions of an ALJ's order that: (1) set aside the self-insured employer's denial of claimant's injury claim for a T11 fracture; and (2) directed the self-insured employer to pay interim compensation.

In order to further consider this matter, we withdraw our July 30, 1999 order. The self-insured employer is granted an opportunity to respond. To be considered, the self-insured employer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT D. AVERY, Claimant
WCB Case No. 98-05623
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
David L. Runner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) affirmed an Order on Reconsideration that characterized claimant's dementia as an "accepted" condition; (2) awarded claimant's attorney a $3,000 assessed attorney fee; and (3) declined to assess a penalty-related fee for SAIF's allegedly unreasonable claim processing. SAIF also moves for remand. On review, the issues are claim processing, remand and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The litigation of SAIF's July 28, 1995 denial of claimant's dementia condition was assigned WCB Case Nos. 95-13779 and 96-01975.

On December 16, 1997, claimant's attorney wrote SAIF to request closure of claimant's injury claim.

On January 8, 1998, SAIF issued a Notice of Conditions Relating to Claim that included the following language:

> "Your claim due to your reported June 19, 1993 [injury] was found compensable by Opinion and Order dated April 24, 1997, and by Order on Review dated October 9, 1997. SAIF Corporation has appealed the Order on Review. Final compensability of your claim has not been determined and SAIF Corporation has not accepted this claim, but is processing it as required by law. Your claim now qualifies for closure and you will receive documents explaining how the closure affects your benefits. SAIF Corporation wants you to understand what conditions are being related to your reported date of injury.
>
> "* * * * *
>
> "The following conditions at this time continue to be related by you and your attorney to your reported June 19, 1993 [injury] while you were employed with [SAIF's insured], but are only being processed as required by law while the Order on Review regarding this denied condition remains on appeal:
>
> "Memory loss due to hypoxic brain injury.
>
> "Again[,] we continue to contest the compensability of your alleged memory loss due to hypoxic brain injury and are only processing that alleged condition as required by law while this matter remains on appeal." (Ex. 11).

The June 18, 1998 Order on Reconsideration included the following language:

> "ACCEPTED CONDITION(S): The following are the accepted conditions for this claim: Superficial and partial thickness burns to hands, face, abdomen and chest and memory loss due to hypoxic brain injury *per the Notice of Conditions Relating to Claim dated January 8, 1998.*
>
> "* * * * *

"Although no Updated Notice of Acceptance at Claim Closure has been issued at this time, it is noted that the denial of the new condition of memory loss due to hypoxic brain injury, dated July 28, 1995, was overturned by Opinion and Order dated April 24, 1997, and affirmed by the Order on Review dated October 9, 1997.

"* * * * *

"The statement made by the Determination Order of March 27, 1998, that the claim does not qualify for closure is reversed. The worker is determined [to] be medically stationary due to the newly accepted condition of 'memory loss due to hypoxic brain injury[.]'

"* * * * * *

"The Determination Order dated March 27, 1998, is rescinded. The worker's newly accepted condition of 'memory loss due to hypoxic brain injury' is determined to be medically stationary as of February 13, 1998, and the claim is remanded to SAIF Corporation for their necessary action." (Emphasis supplied). (Ex. 15)

CONCLUSIONS OF LAW AND OPINION

Claim Processing

We adopt and affirm the ALJ's decision on this issue with the following comment.

On review, SAIF reiterates its argument at hearing that the pending compensability litigation before the Court of Appeals is compromised by language in the June 18, 1998 reconsideration order characterizing claimant's dementia as an "accepted" condition.[1] The ALJ denied SAIF's request to modify the reconsideration order to reflect that it is challenging compensability of the dementia condition and did not voluntarily accept that condition. On review, SAIF asks the Board to either modify the reconsideration order by deleting the characterization of the dementia condition as "accepted," or expressly rule that those references are not legally binding should claimant's dementia ultimately be determined not compensable.

In support of that request, SAIF relies on the ruling in *SAIF v. Mize*, 129 Or App 636 (1994). In *Mize*, SAIF requested judicial review of a Board order finding a claim compensable and, at the same time, accepted the claim without indicating that the acceptance was contingent on its right to appeal the compensability decision. The *Mize* court held that SAIF's unqualified acceptance of the claim rendered the compensability controversy moot and dismissed the petition for judicial review.

Here, the ALJ concluded that the *Mize* ruling is not controlling because, in the present case, SAIF did not issue an unqualified notice of acceptance of the memory loss condition. We agree that the present case is distinguishable from *Mize* on this basis.[2] The June 18, 1998 reconsideration order identifies the accepted condition as dementia *"per the Notice of Conditions Relating to Claim dated January 8, 1998."* (Emphasis supplied). That notice expressly states that SAIF is not accepting the dementia condition and is only processing the claim to comply with litigation orders. Thus, the term "accepted" in the reconsideration order is not used to refer to an unqualified acceptance of claimant's dementia condition, but to a qualified acceptance for claim processing purposes, pursuant to a litigation order. As discussed by the ALJ, such language is consistent with the statutory scheme that recognizes the difference between a "voluntary" acceptance and one that is "a result of a judgment or order." *See* ORS 656.262(6)(c).[3]

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[1] The Board previously concluded that the correct diagnosis of claimant's memory loss condition is "dementia." *Albert D. Avery*, 49 Van Natta 1771 (1997), *on recon* 50 Van Natta 849 (1998). Consequently, we use this diagnosis in our analysis.

[2] We also note that, unlike the law in effect when *Mize* issued, the current statutory and administrative scheme require carriers to issue an updated notice of acceptance at closure that includes conditions found compensable by litigation order. ORS 656.262(7)(c) and OAR 436-030-0015(2)(B)(i).

[3] ORS 656.262(6)(c) provides as follows:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), *whether voluntary or as a result of a judgment or order,* shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition." (Emphasis added).

Furthermore, we held in a case involving this same claim that, pending litigation of the compensability of claimant's memory loss condition, we consider that condition "accepted" (albeit involuntarily) for claim processing purposes. *Albert D. Avery*, 51 Van Natta 814 *on recon* 51 Van Natta 927 (1999). *Accord Thomas W. Clark*, 51 Van Natta 95 (1999) (pending litigation of the compensability of a condition, the Board considers that condition "accepted" (albeit involuntarily) for purposes of issuing a denial under ORS 656.262(7)(b)). In addition, we have previously concluded that a carrier directed by litigation order to accept a claimant's claim may issue a "qualified" acceptance of the claim and continue to assert on appeal of that order that the claimant's condition is not compensable. *Valerie Barbeau*, 48 Van Natta 189 (1997); *Donna J. Calhoun*, 47 Van Natta 454 (1996). Consistent with the rationale expressed in these cases, we conclude that SAIF can continue to contest the compensability of claimant's dementia without appealing the June 18, 1998 Order on Reconsideration.[4] In other words, we conclude that the reconsideration order does not have the preclusive effect asserted by SAIF.[5]

Entitlement to Assessed Attorney Fee

At hearing, claimant asserted that he was entitled to an assessed attorney fee for his counsel's services in this matter. Unless specifically authorized by statute, the Board has no authority to award attorney fees, even though an inequity could result. *Stephenson v. Meyer*, 150 Or App 300, 303 (1997); *Forney v. Western States Plywood*, 297 Or 628, 632 (1984). Here, claimant asserts that he is entitled to an assessed attorney fee under ORS 656.386(1), 656.382(1) or 656.382(2). The ALJ awarded claimant's attorney a $3,000 assessed fee under ORS 656.382(2). On review, SAIF argues that claimant is not entitled to a fee under that provision. In response, claimant reiterates his argument at hearing that he is entitled to an assessed fee under ORS 656.386(1), 656.382(1) or 656.382(2).

We first consider claimant's request for an assessed fee under ORS 656.386(1). Claimant asserts that he is entitled to a fee under this provision "because SAIF denied the accepted condition was accepted." We disagree.

ORS 656.386(1)(a) authorizes an assessed attorney fee where the claimant has finally prevailed over a "denied claim" in a hearing before an ALJ. Pursuant to ORS 656.386(1)(b)(A), a "denied claim" includes "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation." Pursuant to ORS 656.005(6), "claim" means "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." Pursuant to ORS 656.005(8), "compensation" includes "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." *See SAIF Corp. v. Allen*, 320 Or 192 (1994) (in construing *former* ORS 656.386(1), court is bound to follow legislature's definition of terms used in workers' compensation law).

The present case is before us pursuant to SAIF's request for hearing from a reconsideration order that remanded claimant's injury claim to SAIF for closure. SAIF sought to modify language in the reconsideration order to reflect the fact that it has not issued an unqualified acceptance of claimant's dementia condition. Under these circumstances, SAIF's hearing request is not a denial of a "claim for compensation" within the meaning of ORS 656.386(1). *See Safeway Stores, Inc. v. Johnson*, 134 Or App 436-437 (1995) (ORS 656.386(1) does not authorize assessed attorney fee for prevailing over insurer's challenge of PPD award; while PPD is compensation, a PPD award is not a written request for compensation). *But see Ohlig v. FMC Marine & Rail Equipment*, 291 Or 586 (1981) (denial of a request for disability and medical services on causation grounds was a claim for compensation under *former* ORS 656.386(1)).

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[4] We note that ORS 656.262(10) also supports our conclusion that the Order on Reconsideration does not preclude SAIF from later contesting the compensability of the dementia condition. In this regard, ORS 656.262(10) provides that failure to appeal a reconsideration order shall not preclude an insurer from subsequently contesting the compensability of the condition rated therein *unless the condition has been formally accepted*. Because SAIF has not formally accepted the dementia condition and has specified that it is only processing the condition as required by law pending the outcome of the compensability litigation, the Order on Reconsideration will not preclude SAIF from subsequently contesting compensability if the condition is ultimately found not compensable on appeal.

[5] In light of this decision, we need not address claimant's argument that the compensability litigation cannot be compromised because "oral argument in the original case has been completed."

Nor has claimant prevailed over any other denial of a "claim for compensation" within the meaning of ORS 656.386(1). We recognize that SAIF's denial of claimant's dementia condition is a "denied claim" within the meaning of ORS 656.386(1)(b)(A), and that SAIF requested a hearing in this matter to protect its interests in the pending litigation of that denial. Nevertheless, claimant has not prevailed over that denial *in this proceeding*. SAIF did not identify "compensability" as an issue on its hearing request or make any argument regarding the compensability and/or enforceability of the claim for the dementia condition. And the ALJ's findings and conclusions do not address the merits of SAIF's denial of that condition. *Compare Theresha Harrison*, 50 Van Natta 1350 (1998) (no assessed attorney fee under ORS 656.386(1) for prevailing over claim preclusion argument where claimant does not establish that denied condition is compensable on the merits).

In summary, for the reasons set forth above, we conclude that claimant did not prevail over a denied claim for compensation within the meaning of ORS 656.386(1) in this proceeding. Consequently, we have no authority to award an assessed attorney fee under this provision.

We turn to the ALJ's award of an assessed attorney fee under ORS 656.382(2). That provision authorizes an assessed attorney fee when a carrier initiates a hearing request *to obtain* a disallowance or reduction in claimant's compensation award, and the ALJ finds *on the merits* that the compensation award should not be disallowed or reduced. *Deaton v. Hunt-Elder*, 145 Or App 110, 114-115 (1996); *Strazi v. SAIF*, 109 Or App 105, 107-108 (1991).

As discussed above, the ALJ did not render a decision *on the merits* of the compensability of the dementia claim or claimant's entitlement to temporary or permanent disability.[6] Rather, the ALJ addressed a claim processing issue arising from language in a reconsideration order that did not *award* compensation. Regardless of the ALJ's decision on this issue, SAIF would remain responsible for processing precisely the same claim and condition found compensable by the prior Board and ALJ orders. Furthermore, SAIF did not request a hearing *to obtain* a disallowance or reduction in claimant's compensation *award* in this proceeding. SAIF was not seeking a ruling that the dementia condition was not compensable on the merits. Nor was SAIF challenging the amount of disability *awarded*. (In fact, as previously noted, the Order on Reconsideration did not *award* any compensation). Consequently, claimant is not entitled to an assessed attorney fee under ORS 656.382(2), and we reverse the ALJ's decision to the contrary. *Accord Charlotte M. Soros*, 50 Van Natta 2072 (ORS 656.382(2) fee not authorized where ALJ did not issue a decision on the merits, notwithstanding fact that carrier's request for hearing delayed payment of compensation for eight months).

Finally, we conclude that claimant is not entitled to an assessed fee under ORS 656.382(1). Pursuant to that provision, a carrier is liable for an assessed attorney fee if it unreasonably resists the payment of compensation. Here, claimant asserts that SAIF acted unreasonably because it frivolously filed its request for hearing and refused to process the claim to closure pursuant to ORS 656.268. We disagree. SAIF has made a reasonable (although rejected) legal argument that the pending litigation regarding compensability of claimant's dementia condition would be precluded if it were to allow the June 18, 1998 Order on Reconsideration to become final. Under such circumstances, we are not persuaded that SAIF's conduct was unreasonable.

In summary, for the reasons set forth above, we conclude that claimant is not entitled to an assessed attorney fee for his counsel's services at hearing under ORS 656.386(1), 656.382(1) or 656.382(2).[7] We, likewise, conclude that claimant is not entitled to an assessed attorney fee under ORS 656.382(2) for his counsel's services on review.

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[6] We compare this case to our award of an assessed fee under ORS 656.382(2) in the prior proceeding involving this same claim. *See Albert D. Avery*, 51 Van Natta 814 *on recon* 51 Van Natta 927 (1999). In that case, the ALJ concluded that claimant's compensable condition was properly characterized as "dementia" and should not be limited to "brain injury." If the ALJ had concluded otherwise, claimant's compensation would have been reduced because the scope of the compensable condition would have been limited.

[7] In light of our disposition of the attorney fee issue, we need not address SAIF's requests for remand and related assertion that the ALJ did not provide a sufficient rationale to support the amount of his fee.

ORDER

The ALJ's order dated November 30, 1998, as reconsidered on January 19 and February 16, 1999, is affirmed in part and reversed in part. The ALJ's $3,000 assessed attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

August 25, 1999 Cite as 51 Van Natta 1446 (1999)

In the Matter of the Compensation of
MARK W. CAMPBELL, Claimant
WCB Case No. 97-09520
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that: (1) directed it to pay temporary disability benefits from February 18, 1998 through May 12, 1998 and from May 28, 1998 through September 21, 1998; and (2) assessed a penalty for the insurer's late claim acceptance and allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are temporary disability benefits and penalties.

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 $1,700, 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, including the request for a $1,700 attorney fee), the complexity of the issue, and the value of the interest involved. Claimant's attorney 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 April 21, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,700, payable by the insurer.

Board Member Haynes specially concurring.

I agree with the lead opinion's decision to adopt and affirm the ALJ's order and award an attorney fee of $1,700 for claimant's attorney's services on review. I write separately, however, concerning the $1,700 attorney fee award. In claimant's respondent's brief, claimant's attorney requested a $1,700 fee for defending compensation on review. Because the insurer did not respond to claimant's attorney fee request in its reply brief, I am assuming that the insurer does not object to the fee request.

In the Matter of the Compensation of
DAREN L. JOHNSON, Claimant
Own Motion No. 99-0260M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on May 2, 1995. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant has not responded to SAIF's contention.[1] Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question.

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

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

IT IS SO ORDERED.

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[1] On July 26, 1999, claimant requested additional time in which to submit work force documentation. Claimant was granted an extension of 14 days. To date, claimant has not submitted any documentation or argument against SAIF's work force contention. Inasmuch as the 14 day period allotted claimant has expired, we proceed with our review.

In the Matter of the Compensation of
LARRY J. MORGAN, Claimant
WCB Case Nos. 98-09689 & 97-09267
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that reduced claimant's unscheduled permanent disability award for a head injury from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to zero. 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 exception of the finding of ultimate fact. We summarize the pertinent facts as follows:

Claimant, age 43 at the time of hearing, worked for the employer as a plumber. He is also a certified emergency medical technician and has worked as a volunteer firefighter.

On March 22, 1996, while in the course and scope of his employment with the employer, claimant struck the top of his head on a concrete overhang as he ran up some stairs. The blow rendered him unconscious for approximately two minutes. After recovering, claimant worked the remainder of his shift.

Over the next few days, claimant developed a headache and noted a hearing problem in his left ear. On March 28, 1996, while watching television at home, claimant began coughing. He then experienced a sudden, severe headache, followed by nausea, vomiting and left sided paresis. Paramedics were called, who found elevated blood pressure. Claimant was life flighted to the hospital because of concern of an intercranial bleed.

At the hospital, claimant's headache and left sided paresis suddenly resolved. He was nevertheless admitted because of his history, including his preexisting hypertension. Claimant was discharged from the hospital by Dr. Taylor on April 3, 1996 with a diagnosis of post-concussion syndrome after closed head injury and concussion and left acoustic neuroma.

The insurer accepted a claim for concussion. On July 8, 1996, Dr. Taylor released claimant to part-time plumbing work and his fire department duties. Claimant was released to full-time plumbing duties two weeks later. But he complained of headache and dizziness after a few days, and stopped working as a plumber. Claimant continued working at the fire department, however, until March 20, 1997, when he quit because of complaints of vertigo and inability to climb stairs.

Meanwhile, in July 1996, claimant continued to complain of persistent headaches. In August 1996, claimant was diagnosed with sinus disease that Dr. Franzke believed was contributing to claimant's headache problem. In September 1996, claimant was examined by Dr. Kirschner at the insurer's request. Dr. Kirschner diagnosed acoustic neuroma, unrelated to the work injury, hypertension with suspected neurological complications, unrelated to work and post-concussion injury. On the same date, claimant was also examined by Dr. Lindgren, an otolaryngologist, who found a nasal septal deformity, unrelated to the work injury. On December 3, 1996, the insurer denied claimant's neuroma and high blood pressure conditions.

Claimant continued to experience chronic headaches. On March 7, 1997, Dr. Taylor opined that claimant was medically stationary with chronic headaches and lifting restrictions. Dr. Taylor also noted that the cause of the headaches was unclear, but possibly related to his concussion and aggravated by exertion. On March 20, 1997, after learning that claimant had been performing firefighting work for the past several months, Dr. Taylor revised his opinion. He concluded that claimant could return to full-time plumbing work without restrictions. Dr. Taylor also opined at this time that claimant's headaches

and dizziness were probably not related to his mild head injury. In a June 2, 1997 letter to the claims processor, Dr. Taylor indicated that claimant did not suffer any brain damage.

The insurer closed the claim by way of a June 17, 1997 Notice of Closure that awarded temporary disability only. An October 16, 1997 Order on Reconsideration affirmed the Notice of Closure in all respects.

Meanwhile, on October 8, 1997, a hearing was held regarding the insurer's denial of claimant's neuroma. Although claimant did not challenge the denial of high blood pressure, he asserted at hearing that the following conditions were compensably related to his March 22, 1996 injury: post-concussion syndrome, vertigo, dizziness and hearing loss. In a May 13, 1998 Opinion and Order, ALJ Davis concluded that claimant's neuroma and resulting hearing loss were not compensable, but that the March 22, 1998 injury was the major cause of a post-concussion syndrome which included symptoms of vertigo and dizziness.

In response to ALJ Davis' order, the insurer reopened the claim to accept and process claimant's post-concussive syndrome. In a June 1998 report, Dr. Taylor confirmed that claimant's post-concussive syndrome was medically stationary on March 7, 1997. Dr. Taylor also opined that claimant did not have any permanent disability as a result of his accepted concussion and post-concussive syndrome and that any ongoing headaches and dizziness that persisted beyond March 1997 were not attributable to the concussion and/or post-concussive syndrome. Thereafter, on June 10, 1998, the insurer issued a second Notice of Closure awarding no permanent disability.

Claimant requested reconsideration and, on September 28, 1998, was evaluated by Dr. Syna, a neurologist, as a medical arbiter. Claimant advised Dr. Syna that he continued to experience "prostrating" headaches two to three times a week while exerting himself that last for five to 20 minutes. Claimant also complained of light-headedness and dizziness, loss of hearing and memory problems. Dr. Syna concluded that claimant exhibited functional embellishment and that his sensory symptoms and cognitive complaints were unreliable. Dr. Syna also diagnosed post traumatic migraine headaches, noting that, "[a]ccording to [claimant], his headaches require adjustments in work activity and do cause some disruption in activities of daily living." Dr. Syna concluded that claimant's headaches were not completely controlled, and should be classified "possibly as a Class I or Class II."

A November 2, 1998 Order on Reconsideration found that claimant was entitled to a Class I Head/Brain impairment and awarded 14 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to show that he sustained any permanent impairment as a result of his compensable injury and reversed the Order on Reconsideration permanent disability award. On review, claimant contends that the ALJ applied the wrong burden of proof and that the Order on Reconsideration should be reinstated.

We have previously recognized that, in the context of entitlement to permanent disability, a claimant has the burden in the first instance under ORS 656.266. But, when an insurer objects to an Order on Reconsideration and seeks reduction of the award, it has the burden to request a hearing and to show that the standards were incorrectly applied in the reconsideration proceeding. See ORS 656.283(7); *Roberto Rodriguez*, 46 Van Natta 1722 (1994) (citing *Harris v. SAIF*, 292 Or 683 (1982)). Thus, we agree with claimant that the ALJ applied an incorrect standard. Nevertheless, for the reasons set forth below, we conclude that claimant is not entitled to a permanent disability award for his post-concussive syndrome.

We do not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough and well-reasoned evaluation of the claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994). Here, we find that Dr. Taylor, claimant's treating physician, provides the most thorough and well-reasoned assessment of claimant's impairment. Dr. Taylor has been claimant's attending physician since his March 1996 hospital admission. In June 1997, Dr. Taylor opined that claimant did not suffer any permanent brain damage. This opinion was based on his understanding that claimant had been performing volunteer firefighting duties since July

1996 even though claimant had not returned to plumbing work.[1] And, in June 1998, Dr. Taylor confirmed his opinion that claimant did not have any permanent impairment attributable to his concussion and/or post-concussive syndrome. Specifically, Dr. Taylor opined that any reported headaches and dizziness that persisted beyond March 1997 (12 months post-injury) were probably not attributable to the concussion and/or post-concussive syndrome.

Although the medical arbiter opined that claimant's headaches were the result of his traumatic injury and that they caused some interruption in exertional activity, we find this report insufficient to sustain an impairment value under OAR 436-035-0390(10).[2] First, the arbiter's opinion that claimant has a head/brain injury is based solely on claimant's report of headaches rather than any objective examination findings. *See* ORS 656.726(3)(f)(B) (impairment is to be established "by a preponderance of medical evidence based upon objective findings"). Second, the arbiter's report does not establish that these reported headaches constitute an "episodic neurological disorder" ratable under OAR 436-035-0390(10). Third, even the arbiter noted that claimant's complaints and reported symptoms should be considered unreliable, given the high degree of embellishment noted during the examination. We find claimant's report of two to three "prostrating" headaches per week and his report that he has been unable to work since his injury because of an inability to exert himself similarly unreliable.[3] Finally, nowhere does the arbiter indicate that claimant's headache condition is permanent, as required by ORS 656.214(5) and 656.726(f)(A). Therefore, the arbiter's report does not support a permanent partial disability award for a head/brain injury.

Consequently, on this record, we agree with the ALJ that the June 10, 1998 Notice of Closure should be affirmed.

ORDER

The ALJ's order dated April 5, 1999 is affirmed.

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[1] Claimant does not contend that Dr. Taylor's understanding is incorrect, but instead objects to Dr. Taylor's opinion because it is based on hearsay and not corroborated by direct evidence in the record. We do not share claimant's concerns about the reliability of Dr. Taylor's opinion in this case. Indeed, we note that in a prior final order, ALJ Davis expressly found that claimant was on full duty release to the fire department from July 8, 1996 to March 20, 1997 and that, on the latter date, he advised the fire department that he had vertigo and could not climb ladders. (*See* Ex. 39-3). Under such circumstances, the absence of "direct" evidence that claimant's activity level in the latter part of 1996 and the early months of 1997 was inconsistent with his reporting to Dr. Taylor does not undermine the persuasiveness of Dr. Taylor's opinion.

[2] This rule addresses impairment injuries that have resulted in damage to the brain. Class I has a 10 percent impairment and provides as follows:

> "The worker functions at a Rancho Los Amigos Scale of 8; (e.g. the worker is alert and oriented; behavior is appropriate and the worker is able to recall and integrate past and recent events) and the worker is independent in activities of daily living. If there is a language deficit, it is no more than minimal (e.g. language comprehension or production might be less than normal, but it is adequate for daily living). If there are emotional disturbances or personality changes, they are minimal and occur only during stressful situations and events. If there are episodic sleep disturbances and/or lethargy, they are minimal (e.g. any sleeping irregularity or lethargy does not interfere with daily living). If there is an episodic neurologic disorder, it is controlled and does not interfere with daily living."

[3] Indeed, as noted above, it is the law of the case that claimant performed firefighting work between July 1996 and March 20, 1997.

In the Matter of the Compensation of
ROSE E. VENETUCCI, Claimant
WCB Case No. 96-04416
CORRECTED ORDER ON REMAND
Andrew H. Josephson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

It has come to our attention that our August 18, 1999 Order on Remand contained a typographical error. Specifically, the last sentence ordered claimant, rather than SAIF, to pay a penalty. In order to correct this error we withdraw our August 18, 1999 Order and replace it with the following order.

This matter is before the Board on remand from the Court of Appeals. *Venetucci v. Metro*, 155 Or App 559 (1998). The court has reversed our order that affirmed the Administrative Law Judge's dismissal of claimant's request for hearing regarding her objection to the SAIF Corporation's offset of allegedly overpaid temporary disability against her permanent disability award (as granted by a Notice of Closure). Concluding that claimant should have been allowed to proceed to a hearing regarding the merits of the dispute, the court has reversed and remanded.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We first briefly recount the procedural history of the case. Claimant, employed through a union hall call board, suffered a compensable heel injury. SAIF originally calculated claimant's average weekly wage at $515 and paid temporary disability based on that amount from August 25, 1993 through December 15, 1993. On May 18, 1994, SAIF sent claimant a Notice of Closure. That notice provided that the deduction of overpaid temporary disability, if any, from unpaid permanent disability was approved. Claimant was not awarded permanent disability in the Notice of Closure.

On June 16, 1994, a SAIF audit asserted that claimant's modified weekly wage rate was $374 and that SAIF had made an overpayment of $2,392.05. SAIF mailed claimant notice of this alleged overpayment the next day, indicating that it would offset off the overpayment against any future awards of permanent disability.

On claimant's motion for reconsideration, the Department rescinded the May 18, 1994 closure as prematurely issued. SAIF issued a second Notice of Closure on October 30, 1995. It provided an award of 5 percent ($2,237.02) scheduled permanent partial disability. That closure notice contained the same general language as the first regarding overpayment and offset. Nothing in the second notice, however, referred specifically to an actual overpayment.

On November 28, 1995, SAIF advised claimant by letter that the alleged overpayment was being deducted from her award for permanent partial disability and that the net payable award was zero. Claimant did not request reconsideration of the second Notice of Closure, but instead sought a hearing, contesting SAIF's amended calculation of her weekly income and alleged overpayment and seeking penalties.

SAIF moved to dismiss the request for hearing based on ORS 656.268(4)(e), which provides that, if a worker objects to the notice of closure, the worker first must request reconsideration by the department within 60 days of the date of the notice of closure. SAIF argued that claimant's objection was to the second notice of closure and that, having failed to seek reconsideration of that notice, she was prohibited from proceeding directly to hearing. The ALJ agreed, relying on *William T. Masters*, 48 Van Natta 1788 (1997). We adopted and affirmed the ALJ's order. Claimant sought judicial review.

The court reversed and remanded, reasoning that, for the mandatory reconsideration pursuant to ORS 656.268(4)(e) to preclude further review, a claimant must have an objection that is manifest in the Notice of Closure. Concluding that claimant's objection to the offset arose from her receipt of SAIF's letter announcing its intent to withhold payment of permanent disability, the court determined that SAIF's intent to withhold claimant's permanent disability award was not manifest from the Notice of Closure. *Venetucci v. Metro*, 155 Or App at 564.

In light of the court's decision, we must now determine the underlying issues in this case, which are whether SAIF correctly calculated claimant's wage rate for purposes of paying temporary partial disability and properly asserted an overpayment against the award of scheduled permanent disability. We now proceed with our analysis of those issues.

SAIF initially calculated claimant's temporary disability rate of $510 based on an hourly rate of $12.75 and the assumption of a five-day per week, 40 hour per week schedule. At the time of the May 18, 1994 claim closure, SAIF audited the file and recalculated the average weekly wage when it noticed that, on the form 801, claimant was listed as a part-time on-call worker. Applying *former* OAR 436-60-025(5)(a), SAIF determined that claimant' weekly wage should be $374 based on the average of her actual earnings. The recalculation resulted in the alleged overpayment of $2,392.05.

Although the ALJ did not reach the merits of the claim processing and penalty issues because of his determination of the procedural issue, the ALJ stated that he would have held that the recalculation of temporary disability was improper, reinstated the permanent disability award, and assessed penalties. Based on our review of the substantive issues, we reach similar conclusions.

Claimant argues that the proper rule to apply in calculating the temporary disability rate of a union hall call board employee is contained in *former* OAR 436-60-025(2)(c). That rule provided:

> "For workers employed through union hall call board insurers shall compute the rate of compensation on the basis of a five-day work week, regardless of the number of days actually worked per week."

SAIF does not dispute that the above rule would normally apply to workers such as claimant who are employed through the union hall call board. SAIF argues, however, that, for the rule to apply, claimant must prove that she was available for full-time work through the union hall call board. SAIF contends that claimant failed to prove availability for full-time work and that, therefore, *former* OAR 436-60-025(2)(c) does not apply. Accordingly, SAIF alleges that it properly used the averaging method provided in *former* OAR 436-60-025(5)(a). We disagree with SAIF's contention that the record does not establish that claimant was available for full-time work.

Although SAIF correctly observes that claimant did not testify that she was available for full-time work when injured, payroll records for the period prior to the compensable injury were entered into evidence. They show that, while claimant's hours varied, she did on occasion work in excess of 40 hours per week. (Ex. 18). From this evidence, we find that claimant was available for full-time work through the union hall call board. Further, because SAIF does not dispute that a claimant who was available for full-time work through the union hall call board should have his or her temporary disability calculated according to the union hall call board rule, we conclude that SAIF improperly reduced claimant temporary disability rate from $510 to $374. Therefore, it erroneously asserted a $2,392.05 overpayment. Because no such "overpayment" truly existed, it follows that SAIF should have paid claimant the entire amount of the permanent disability awarded in the October 1995 closure notice.[1]

We now proceed to a determination of whether SAIF's claim processing was unreasonable when it recalculated the temporary disability rate, asserted an overpayment and declined to pay claimant's permanent disability award. For the following reasons, we conclude that it was unreasonable.

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[1] SAIF asserts that, should we determine that it improperly reduced claimant's temporary disability rate, we should not order the payment of claimant's permanent disability award. SAIF argues that payment of the permanent disability award is a claim processing matter that should not be decided in this forum. It contends that claimant may still not be entitled to the entire permanent disability award because of the fact that she earned wages while receiving temporary disability. Thus, according to SAIF, claimant may have still been overpaid even at the higher temporary disability rate. We decline SAIF's request to further delay payment of claimant's scheduled permanent disability award. Claimant's request for hearing arose out of SAIF's failure to pay her the 5 percent scheduled permanent disability award. Inasmuch as we have determined that the basis for SAIF's alleged overpayment was unfounded, if follows that SAIF's decision not to pay the permanent disability award was erroneous. SAIF's reference to an additional ground for challenging payment of the permanent disability award is essentially an attempt to raise a new issue and further develop the record. The appropriate time for this was at hearing, not 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). Moreover, under these circumstances (particularly considering SAIF's belated additional challenge), we find no compelling reason to remand for further development of the record regarding the offset issue. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

A penalty can be assessed under ORS 656.262(11)(a) if the carrier's failure to pay benefits was unreasonable. Whether a carrier's actions are unreasonable is determined by whether it had a legitimate doubt, from a legal standpoint, about its liability. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988).

Here, SAIF's auditor testified that her recalculation was triggered by the notation on the form 801 indicating that claimant was a part-time worker. (Tr. 18). The auditor also testified, however, that she had available to her the information contained in exhibit 18, which we have held establishes that claimant was available for full time work as a union call board employee. (Tr. 31). Because application of OAR 436-60-025(2)(c) to a union call board worker is clear for the language of the rule, and SAIF was aware at the time of its audit that this was a union call board claim (Tr. 23), we find that SAIF did not have a "legitimate doubt" regarding its liability for payment of benefits. Therefore, we hold that SAIF's recalculation of the temporary disability rate (as well as its assertion of an overpayment and failure to pay the full permanent disability award) was unreasonable. Thus, we conclude that claimant is entitled to a 25 percent penalty on all amounts due under ORS 656.262(11), *i.e.*, the "withheld" 5 percent scheduled permanent disability award.

In addition, because we have ordered payment of the scheduled permanent disability awarded by the Notice of Closure, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the 5 percent "withheld" scheduled permanent disability award), not to exceed $3,800, payable directly to claimant's counsel. *See* ORS 656.386(2); OAR 438-015-0055(1).

Accordingly, on remand, the ALJ's order dated November 22, 1996 is reversed and claimant's request for hearing is reinstated. Claimant's temporary disability rate is to be based on an average weekly wage of $510. SAIF is ordered to pay claimant's 5 percent scheduled permanent disability award. SAIF shall pay 25 percent of the increased compensation created by this order (the 5 percent "withheld" permanent disability award), not to exceed $3,800, directly to claimant's counsel. SAIF shall also pay a 25 percent penalty based on the amount of the "withheld" permanent disability, one-half of the penalty to be paid to claimant's attorney and one-half to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLAUDIA A. YELDIG, Claimant
WCB Case No. 98-03910
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's denial of her claim for an umbilical seroma and for an infection of the seroma. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a licensed practical nurse, had been diagnosed with an umbilical hernia in approximately 1989, but no surgery was required. (Ex. 1). On December 20, 1995, the hernia became incarcerated after moving a patient. (Exs. 1, 4). Dr. Imatani performed an umbilical hernia repair the following day. (Ex. 2). The employer accepted an incarcerated umbilical hernia. (Ex. 5). The claim was closed on April 10, 1996 with an award of temporary disability. (Ex. 8).

On May 12, 1997, claimant was admitted to the hospital for cellulitis of her right lower extremity. (Ex. 10). On May 26, 1997, Dr. Lim reported that while claimant was in the hospital, she noticed that the hernia repair site had not really subsided. (Ex. 13). A CT scan showed a seroma. (*Id.*) Dr. Lim diagnosed an infected "hematoma" at the ventral hernia repair site and he performed an incision and drainage of the "hematoma." (Exs. 13, 14).

Dr. Imatani examined claimant on June 9, 1997. (Ex. 16). He reported that the CT scan showed the seroma was unassociated with any obvious abdominal wall defects and "it was assumed that her seroma got secondarily infected from her active cellulitis involving the left lower leg." (*Id.*)

Claimant continued to have problems with both the infected seroma and the cellulitis condition. On March 24, 1998, Dr. Yu performed an excision of claimant's umbilicus. (Ex. 39). Claimant testified that the wound healed after the March 1998 surgery. (Tr. II-8, -9).

In May 1998, Dr. Avison signed an aggravation claim for claimant's cellulitis and seroma conditions. (Exs. 45, 46). On May 14, 1998, the employer denied claimant's aggravation claim for an umbilical hernia on the basis that it was not filed in a timely manner. (Ex. 47). Claimant requested a hearing on the May 14, 1998 denial. On October 8, 1998, the employer denied the claim for a cellulitis condition. (Ex. 54). The cellulitis denial became final by operation of law. (Tr. II-4).

Dr. Goodall, a specialist in infectious diseases, examined claimant on behalf of the employer (Ex. 53) and testified at the hearing.

CONCLUSIONS OF LAW AND OPINION

The issues at hearing were whether claimant's seroma was a consequential condition and, if so, whether the infection of the seroma was compensable.[1] (Tr. II-1, -2). The ALJ determined that, even assuming the seroma was a compensable consequential condition, the infection of the seroma was not compensable because it did not flow "directly and inexorably" from the compensable injury.

Claimant argues that the ALJ erred by not determining compensability of her seroma and by finding that the infected seroma was not compensable. Claimant relies on the opinions of Drs. Avison and Imatani to contend that the seroma was a consequence of her compensable hernia condition and that the existence of the seroma was the major contributing cause of the seroma infection.

We first address compensability of claimant's seroma condition. To establish compensability under ORS 656.005(7)(a)(A), claimant must prove that the compensable injury is the major contributing cause of the consequential condition, *i.e.*, that the accepted incarcerated hernia is the major contributing cause of the seroma. Claimant contends that the seroma resulted from treatment for the hernia condition. Where a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is deemed to be the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A). *Barrett Business Services v. Hames*, 130 Or App 190, 193, *rev den* 320 Or 492 (1994).

Because of the multiple possible causes of claimant's seroma and the infection of the seroma, the causation issues present complex medical questions that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

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[1] The employer argues that claimant never made a claim simply for a seroma, although she did make a claim for an *infected* seroma. Claimant disagrees, pointing out that Dr. Avison referred to both the seroma and its infection. (Ex. 45). At the January 13, 1999 hearing, the parties agreed that the question of untimely filing of the aggravation claim was no longer an issue. (Tr. II-1). The employer's denial was amended to deny that a seroma condition was a consequential condition and, even if it was found to be a consequential condition, the infection of the seroma was not compensable. (*Id.*) The ALJ said that the issues were whether claimant's seroma was a consequential condition and, if so, whether the infection of the seroma was compensable. (Tr. II-1, -2).

We are not persuaded that claimant did not make a claim for the seroma condition. In any event, we find no evidence that the employer objected to the ALJ's characterization of the issues to be litigated. Parties to a workers' compensation proceeding may, by express or implicit agreement, try a case by agreement with a particular issue in mind. *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990).

Claimant relies on the opinions of Drs. Avison and Imatani, her treating physicians, to establish compensability of the seroma and the infection of the seroma. In evaluating medical opinions, absent persuasive reasons to the contrary, we generally defer to the treating physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, however, we find that the dispute involves expert analysis rather than expert external observations, and therefore, the status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284, 287 (1986); *Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979).

The employer acknowledges that the treatment for the accepted incarcerated umbilical hernia (*i.e.*, hernia repair) was probably adequate and appropriate. Therefore, the seroma condition is compensable if it was the "direct result" of reasonable and necessary treatment of the accepted hernia. *See Hames*, 130 Or App at 193.

Dr. Avison has been treating claimant since the 1980's. (Ex. 48). Beginning in May 1997, she treated claimant for the cellulitis and infected seroma. Dr. Imatani also treated claimant, beginning in 1995 when he performed an umbilical hernia repair. (Ex. 2). On June 9, 1997, Dr. Imatani examined claimant's infected seroma. (Ex. 16). He reported that a CT scan showed the seroma was unassociated with any obvious abdominal wall defects and "it was assumed that her seroma got secondarily infected from her active cellulitis involving the left lower leg." (*Id.*)

In concurrence letters from claimant's attorney, Drs. Avison and Imatani agreed that claimant's seroma was probably a result of the 1995 hernia. (Exs. 51, 52). In a later concurrence letter from the employer's attorney, Dr. Imatani agreed that the seroma had resulted from the surgery. (Ex. 56-1).

We are not persuaded by the opinions of Drs. Avison and Imatani because they are conclusory. They agreed that claimant's seroma was "probably a result of the 1995 hernia" (Exs. 51, 52), and Dr. Imatani agreed that the "seroma resulted from the surgery[.]" (Ex. 56-1). They did not explain why or if the seroma was a direct result of the treatment for the incarcerated hernia. Moreover, we find no evidence that Drs. Avison and Imatani considered and weighed the relative contribution of other factors that may have caused claimant's seroma. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Their opinions are not sufficient to establish compensability of the seroma.

Instead, we are more persuaded by the opinion of Dr. Goodall, specialist in infectious diseases. He reported that claimant had developed a seroma as a "secondary effect of the hernia repair[,]" but it did not warrant any further intervention. (Ex. 53-1). Dr. Goodall believed that the residual seroma could be considered a complication of the surgery. (Ex. 53-3). He explained:

> "I don't think a breakdown of the original hernia repair is the problem. I think that the original repair was probably appropriate and adequate but that postoperatively she developed a subcutaneous collection of serous fluid, *which is more related to her obesity than to a direct complication of the repair itself.*" (*Id.*; emphasis supplied).

Claimant contends that Dr. Goodall's opinion is not persuasive because he did not explain the "change" in his opinion. We do not find that Dr. Goodall changed his opinion. Although he acknowledged that claimant's seroma could be considered a complication of the hernia surgery and was a "secondary effect" of the hernia repair, his opinion does not establish that the seroma was a direct result of the treatment for the incarcerated hernia. Rather, he felt the seroma was more related to claimant's obesity. We conclude that claimant has failed to establish that her seroma is a compensable consequential condition.

Moreover, even if we assume that the seroma is compensable, we conclude that the infection of the seroma is not compensable. Claimant relies on the opinions of Drs. Avison and Imatani to establish compensability of the infected seroma. In concurrence letters from claimant's attorney, Dr. Avison agreed that claimant's seroma became infected with bacteria from the cellulitis. (Exs. 51, 52). Dr. Avison agreed that the seroma created an anaerobic environment, ripe for the growth of bacteria and, without this ideal environment for the growth of bacteria, there would have been no infection. (Ex. 51). Dr. Avison agreed that the infection was caused in major part by the "environment created by the seroma." (*Id.*) Dr. Avison's opinion is not persuasive because she did not discuss the relative contribution of other factors that may have caused the infected seroma. In addition, Dr. Avison's opinion is conclusory and lacks adequate explanation.

Dr. Imatani agreed that claimant's seroma became infected from the cellulitis. (Ex. 52). Although he initially agreed that there would have been no infection without the seroma's "ideal environment" for the growth of bacteria (Ex. 52), he later changed his opinion. In a concurrence letter from the employer's attorney, Dr. Imatani agreed that the seroma had resulted from the surgery, but would not have become infected if claimant had not developed a secondary infection, *i.e.*, the cellulitis. (Ex. 56-1). He also agreed that the cellulitis "was not caused or worsened by the hernia repair but was the result of long-standing lymphedema and venous stasis disease." (*Id.*) In a later concurrence with claimant's attorney, Dr. Imatani agreed that it was probable that the infection was caused in major part by the "environment created by the seroma." (Ex. 57). Dr. Imatani's opinion is not well-reasoned. Moreover, because he did not explain his apparent change of opinion regarding causation of claimant's infected seroma, we do not find his opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

In contrast, we are persuaded by Dr. Goodall's well-reasoned opinion. Dr. Goodall testified that the major cause of claimant's infected seroma was the leg cellulitis,[2] which resulted in "seeding" the preexisting seroma. (Tr. II-16, -17). He explained that the resultant transient bacteremia from claimant's cellulitis resulted in a secondary infection of the previously existing seroma. (Ex. 53-2). He believed that the major contributing cause of claimant's cellulitis was her obesity and underlying lymphedema.[3] (Ex. 53-2, -3; Tr. II-15). Dr. Goodall did not believe claimant's hernia surgery in 1995 had anything to do with causing cellulitis. (Tr. II-15). He agreed that it was "[n]ot at all" inevitable that the seroma would have become infected simply because it was there. (Tr. II-19). He said that a necessary prerequisite for the infection was the "episode of transient bacteremia, which is to say bacteria carried in the bloodstream for long enough so that the immune defense system could not deal with it[.]" (*Id.*) Dr. Goodall felt that the likelihood of a seroma becoming infected, absent some other infectious problem, was "significantly less than 10 percent." (*Id.*)

Claimant contends that Dr. Goodall's opinion is not persuasive because he changed his opinion without explanation. She asserts that, despite his previous opinion that her seroma had "laid the ground work" for the infection and that it was "instrumental" in the need for surgery, he later said that the major cause of the infection was claimant's cellulitis condition. We do not agree with claimant that Dr. Goodall's opinion was inconsistent. In his September 28, 1998 report, he explained that the seroma "laid the ground work" for the abscess formation and was "instrumental" in the need for the later surgery. (Ex. 53-3). Dr. Goodall clearly acknowledged that claimant's seroma was a factor in later developing an infected seroma. Nevertheless, he distinguished between "a cause" and the "major contributing cause" of the infected seroma. When asked about the "major" cause of the infected seroma, Dr. Goodall said that the leg cellulitis was the major cause of that condition. (Tr. II-17). We do not agree that Dr. Goodall's opinion is inconsistent.

We find that the issue of compensability of claimant's seroma infection involves expert analysis rather than expert external observations. Thus, the opinions of Drs. Avison and Imatani are not entitled to any particular deference as treating physicians. Moreover, as a specialist in infectious diseases, we find that Dr. Goodall has superior expertise in determining causation of claimant's seroma infection. Dr. Goodall's opinion was more complete and better-reasoned than the opinions of Drs. Avison and Imatani and we find his opinion more persuasive. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980). Based

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[2] Dr. Goodall explained that cellulitis is a "rather generic term indicating infection of the soft tissues, which is to say primarily the skin and subcutaneous tissues usually caused by bacteria, which have [seeded] into that area often in the microscopic fashion through pores in the skin or through hair follicles, etc." (Tr. II-14, -15).

[3] After examining claimant, Dr. Goodall reported that claimant had chronic severe lymphedema of both lower extremities secondary to morbid obesity. (Ex. 53-2). At hearing, he described lymphedema as follows:

> "[T]he circulatory system moves blood from the arterial side to the venous side, and in the process, some of the fluid leaks out of the capillaries into the tissues. There is a fairly efficient system for recirculating that edema or that fluid back into the circulation. In a variety of clinical situations, that ability to recirculate the fluid is compromised, as a result of which the fluid tends to pool in the tissues, particularly in dependent tissues, and that was the situation of the claimant." (Tr. II-14).

Dr. Goodall explained that the cause of the "pooling" in claimant was morbid obesity. (*Id.*)

on Dr. Goodall's opinion, we conclude that claimant's noncompensable cellulitis[4] was the major contributing cause of the seroma infection. (Tr. II-17). Therefore, even if we assume that the seroma condition is compensable, claimant has not met her burden of proving that the infection of the seroma is compensable.

ORDER

The ALJ's order dated April 23, 1999 is affirmed.

[4] We note that claimant did not appeal the employer's denial of her claim for cellulitis.

In the Matter of the Compensation of
HARRY R. BOSTWICK, Claimant
Own Motion No. 99-0231M
OWN MOTION ORDER
Cigna Ins. Co., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on February 9, 1977. The insurer agreed that claimant's current right knee was causally related to his accepted condition and that it is responsible for claimant's current condition. However, the insurer initially opposed reopening on the grounds that claimant was not in the work force at the time of the current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). Here, claimant must prove that he was in the work force on February 26, 1999, when his condition worsened requiring surgery. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In response to the insurer's work force contentions, claimant asserts that he sustained a work-related injury to his left leg for which he underwent surgery and was "off a total of 26 months with my left leg." As a result of that surgery, he argues that he was unable to work.

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). In other words, the relevant time period for which claimant must establish that he was in the work force is the time prior to when his compensable condition worsened requiring surgery and/or inpatient hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, on February 26, 1999, Dr. Colville, claimant's attending physician, recommended that claimant undergo a re-fusion of his right knee. At that time, claimant was receiving temporary disability under an accepted left knee claim with another carrier. Since claimant was receiving temporary

[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).

disability compensation in another workers' compensation claim at the time of his disability in this claim, he is considered to be in the work force.[2] *See Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Therefore, we conclude that claimant did not voluntarily remove himself from the work force, but, rather, was disabled due to another compensable injury which prevented him from working at the time of his current worsening. Consequently, we find that claimant has established that he was in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's 1990 claim to provide temporary disability compensation beginning the date he is hospitalized for the proposed surgery.[3] When claimant is medically stationary, the insurer shall closed the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[2] The insurer responded to claimant's submission and agreed that "[claimant] was within the work force given that he was receiving compensation on another workers' compensation claim."

[3] In making this authorization, we note that claimant sustained a separate work injury for which he received time loss benefits. Claimant is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if claimant is hospitalized for the proposed right knee re-fusion surgery during a period that he is entitled to time loss for his left knee injury claim, the insurer is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. *See* OAR 436-060-0020(8); *Leroy R. Fowler*, 41 Van Natta 1468 (1989).

In the Matter of the Compensation of
ANITA CHRISTENSEN, Claimant
Own Motion No. 99-0261M
OWN MOTION ORDER
Scott M. McNutt, Sr., Claimant Attorney

The self-insured employer initially submitted claimant's request for temporary disability compensation for claimant's compensable 1989 industrial injury. Claimant's aggravation rights on that claim expired on August 3, 1994.

On February 8, 1993, the Board approved the parties' Claim Disposition Agreement (CDA), which fully released claimant's rights to the following "non-medical service" workers' compensation benefits: temporary disability benefits, permanent disability benefits, vocational rehabilitation, aggravation rights per ORS 656.273, and survivor's benefits.

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

In light of the fact that claimant has fully relinquished her rights to temporary disability compensation as a result of the February 8, 1993 CDA, she is no longer entitled to any temporary disability compensation related to her March 17, 1989 work injury. *See* ORS 656.236(1); *Jack F. Stewart*, 51 Van Natta 22 (1999); *Jeffrey B. Trevitts*, 46 Van Natta 1767 (1994), *aff'd Trevitts v. Hoffman-Marmolejo*, 138 Or App 455 (1996).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY A. DELFS, Claimant
Own Motion No. 99-0285M
OWN MOTION ORDER

The self-insured employer has voluntarily reopened claimant's claim pursuant to ORS 656.278 for his compensable low back condition. Claimant's aggravation rights expired on May 22, 1996. The employer asks the Board to authorize the reopening of claimant's claim.

The employer voluntarily reopened claimant's claim for the payment of temporary disability compensation. However, claimant is entitled to temporary disability benefits only if he qualifies for those benefits under the relevant statutory provisions. *Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990). Pursuant to ORS 656.278(1)(a), 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. 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. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

The insurer contends that claimant was retired at the time of the current disability and therefore not in the work force. Claimant has not responded to the Board's inquiry nor to the insurer's contention.[1] Claimant has the burden of proof on this issue and must provide evidence on that issue (e.g., copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question).

The information submitted to us to date does not demonstrate claimant's presence in the work force at the relevant time. 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.

The employer's gratuitous payment of temporary disability compensation is permitted by statute and is within the employer's discretion. *See* ORS 656.278(5); *Allen E. Orton*, 42 Van Natta 924 (1990). However, inasmuch as those benefits were not properly paid pursuant to the Board's own motion authority, we shall not authorize the reopening of the claim. ORS 656.278(1)(a).

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

IT IS SO ORDERED.

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[1] On August 2, 1999, the Board requested claimant's position regarding the insurer's contention that claimant is retired. The Board requested that such information be received within 14 days from the date of the letter. Inasmuch as the 14 day period has expired, we have proceeded with our review.

In the event that claimant disagrees with our decision that he has withdrawn from the work force, he may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, he should submit his information as soon as possible.

In the Matter of the Compensation of
DONALD J. NEIL, JR., Claimant
WCB Case No. 98-08074
ORDER ON REVIEW

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that dismissed his request for hearing on the basis that the Hearings Division lacked jurisdiction over the matter. On review, the issues are jurisdiction and, if jurisdiction is established, penalties.

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

Claimant was compensably injured in a motor vehicle accident in California on September 25, 1995. After some confusion concerning the state in which he was employed, claimant filed a claim in Oregon. His employer, H & F Metals, was found to be noncomplying, and the claim was assigned to a claims agent. The claims agent subsequently accepted claimant's claim.

On October 12, 1998, claimant, through his former attorney, filed a request for hearing, seeking penalties and attorney fees arising out of the alleged failure to timely pay his permanent disability benefits. At the hearing (in which claimant appeared *pro se*) claimant confirmed that a penalty was the only issue. Based on this concession, the ALJ dismissed claimant's request for hearing for lack of jurisdiction pursuant to ORS 656.262(11)(a).[1]

On review, claimant does not address the jurisdiction issue. Instead, claimant renews his request for a penalty and raises several other issues concerning the processing and closure of his claim. But, because these other issues were not specified in the hearing request or otherwise raised at the hearing, they do not serve to confer our jurisdiction over this matter. In other words, although the Hearings Division and the Board have jurisdiction when the penalty issue is combined with other issues,[2] claimant did not timely raise or preserve any other issues in this proceeding. *See Stevenson v. Blue Cross*, 108 Or App 247 (1991) (as a general rule, Board will not consider issues that are raised for the first time on review).

Because the ALJ's scope of review is limited to the issues raised by the parties at hearing, *see, e.g., Alden D. Muller*, 43 Van Natta 1246 (1991), and the only issue raised by the parties at the hearing in this case was the penalty, the ALJ properly dismissed claimant's request for hearing for lack of jurisdiction pursuant to ORS 656.262(11)(a). *See Corona v. Pacific Resources Recycling*, 125 Or App 47 (1993) (the Director has exclusive jurisdiction where the sole issue is the entitlement to a penalty); *Robert Geddes*, 47 Van Natta 2388 (1995) (same).

ORDER

The ALJ's order dated April 23, 19999 is affirmed.

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[1] ORS 656.262(11)(a) provides, in pertinent part, as follows:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. *Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection.*" (Emphasis added).

[2] For example, Hearings Division and Board retain jurisdiction where the claimant raises entitlement to temporary disability as well as penalties. *See Marsha E. Westenberg*, 49 Van Natta 2178 (1997). Similarly, where the claimant seeks enforcement of an unsatisfied ALJ or Board order, we have have jurisdiction over the assessment of any related penalties. *See Leonard W. Kirklin*, 48 Van Natta 1571 (1996).

In the Matter of the Compensation of
STEPHEN G. RAMBERG, Claimant
Own Motion No. 99-0266M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable low back condition. Claimant's aggravation rights expired on November 17, 1992.

The insurer submitted its Own Motion Recommendation form which responds affirmatively to all the criteria that claimant must meet in order to qualify for temporary disability benefits.[1] However, the insurer opposes the reopening of the claim on the grounds that the surgery claimant underwent did not establish an "actual worsening" of his current condition pursuant to ORS 656.273(1).

The insurer's recommendation that we deny reopening of the claim because his condition had not "worsened" is not well founded. Under ORS 656.273(1)(b), a worsening is not established by "[i]npatient treatment of the worker at a hospital for the worker's condition from the original injury." However, ORS 656.273(1)(a) is not applicable because claimant's 1992 claim is in the exclusive jurisdiction of our own motion authority under ORS 656.278. *See Jody Crompton*, 48 Van Natta 1183 (1996).

In *Crompton*, the self-insured employer argued that claimant's surgery (right carpal tunnel release) did not represent a "worsening" of claimant's compensable condition pursuant to ORS 656.273(1)(b). As a result, the employer contended that there was "no valid aggravation upon which the Board may exercise its own motion jurisdiction." We found that the employer's reliance on the definition of a "worsening" as set forth in ORS 656.273(1)(b) misplaced. We took this position based on the following reasoning.

The claimant's original claim had been accepted as nondisabling in September 1989. Pursuant to ORS 656.273(4)(b), a claim for aggravation of a nondisabling injury must be made within five years after the date of injury. ORS 656.278(1)(a) confers upon us exclusive jurisdiction in our own motion capacity over "aggravation" claims made after the five year period has expired. The claimant's aggravation rights expired in September 1994. The claimant filed a "worsening" claim in December 1994. Thus, the "worsening" arose after claimant's aggravation rights on the 1989 claim had expired. Consequently, we had exclusive own motion jurisdiction over this claim. ORS 656.278; *Miltenberger v. Howard's Plumbing*, 93 Or App 475, 477 (1988).

Inasmuch as we had exclusive own motion jurisdiction over the claimant's 1989 claim, we turned to whether the claimant was entitled to temporary disability benefits as set forth in ORS 656.278. Pursuant to ORS 656.278(1)(a), we may reopen a claim for temporary disability benefits under our own motion authority when we find that "[t]here is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization." Thus, we found that pursuant to ORS 656.278(1)(a), a "worsening" of an own motion claim is defined as requiring inpatient or outpatient surgery or other treatment requiring hospitalization. *Jody Crompton*, 48 Van Natta at 1183; *Tamera Frolander*, 45 Van Natta 968 (1993).

We noted in *Crompton*, that our conclusions regarding the definition of a worsening in claims within our exclusive own motion authority was contrary to the definition of a worsening pursuant to ORS 656.273(1)(b). However, because claimant's 1989 claim was controlled by ORS 656.278, we concluded that the provisions of ORS 656.273 did not apply to the claimant's claim.

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[1] The insurer did not respond to the question regarding claimant's "work force" status. However, claimant submitted a copy of a July 1999 work history questionnaire which demonstrates that he was in the work force at the time of his disability. The insurer has not responded to claimant's submission. As a result, we conclude that the insurer is not disputing claimant's assertion that he was in the work force when his condition worsened requiring surgery, *i.e.* June 25, 1998.

Here, claimant's aggravation rights expired in November 1997 for his compensable 1992 claim. Claimant's condition "worsened" requiring surgery in June 1998 after his five year aggravation period expired. Accordingly, claimant's "aggravation" of his 1992 claim falls within our exclusive own motion authority. As noted above, a worsening in an own motion claim is defined as requiring inpatient or outpatient surgery or other treatment requiring hospitalization. *Id.*

Inasmuch as claimant underwent surgery at L5-S1, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary total disability compensation beginning June 25, 1998, the date claimant was hospitalized for 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
RICHARD M. HENRY, Claimant
WCB Case No. 99-00232
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's denial of claimant's aggravation claim. On review, the issue is aggravation.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated April 23, 1999 is affirmed.

Board Member Phillips Polich specially concurring.

I agree with the ALJ that the medical evidence in this case is insufficient to establish an "actual worsening" of claimant's compensable condition under ORS 656.273. I write separately to articulate my reasoning and conclusion.

Claimant was compensably injured in April 1997 when he fell through a roof. SAIF accepted compression fractures of T11 and T12, along with a fracture of the left wrist and a fracture of the left inferior pubic ramus. Claimant's treating physician, Dr. Ballard, released him to regular work in September 1997. SAIF closed the claim by way of a November 10, 1997 Notice of Closure that awarded 2 percent scheduled permanent disability and 4 percent unscheduled permanent disability. Claimant requested reconsideration and a medical arbiter examination.

In early February 1998, claimant experienced an exacerbation of back pain and began treating with Dr. Olson. Meanwhile, on February 23, 1998, claimant was examined by Dr. Becker, a medical arbiter, in connection with the reconsideration proceeding. Dr. Becker found a loss of motion in the left wrist and thoracic area. A March 18, 1998 Order on Reconsideration modified claimant's permanent disability award, and awarded him 6 percent scheduled permanent disability and 3 percent unscheduled permanent disability.

Claimant continued to treat with Dr. Olson for intermittent back pain for the next few months. On May 11, 1998, Dr. Olson signed a Notice of Aggravation Claim form on claimant's behalf. On June 11, 1998, Dr. Olson reported that claimant was still experiencing intermittent pain, but had reached maximal improvement. Dr. Olson expected that claimant's symptoms would wax and wane.

The ALJ concluded that Dr. Olson's reports were insufficient to show an actual worsening of claimant's condition under ORS 656.273(1) and the standard set forth in *SAIF v. Walker*, 145 Or App 294 (1996). I agree.

In *Walker*, the court discussed the meaning of the phrase "actual worsening" in the context of a worker's burden of proof in establishing a compensable aggravation under ORS 656.273(1). The court held that, in order for a symptomatic worsening to constitute an "actual worsening"

> "*[A] medical expert must conclude that the symptoms have increased to the point that it can be said that the condition has worsened.* In other words, ORS 656.273(1), as amended, requires that there be *direct medical evidence that a condition has worsened.* It is no longer permissible for the Board to infer from evidence of increased symptoms that those symptoms constitute a worsened condition for purposes of proving an aggravation claim." 145 Or App at 305 (emphasis added).

In this case, no medical expert has concluded that claimant's symptoms have increased. Also, there is no direct evidence that claimant's condition has worsened. Although Dr. Olson's reports document objective findings (including a non-healed compression fracture and back spasms), Dr. Olson does not report that claimant's condition had worsened. And in the absence of some comparative analysis of claimant's condition by Dr. Olson or another medical expert, I cannot determine whether claimant's documented findings and symptoms represent a worsened condition or a simple waxing and waning. While the former is sufficient to sustain an aggravation claim, the latter is not.

I acknowledge that "magic words" are not necessary, and I am not suggesting that the medical expert's opinion must include the word "worsened." But, mindful of the fact that it is no longer permissible for the Board to infer a worsened condition from evidence of increased symptoms, *see SAIF v. Walker*, 145 Or App at 305, I believe the medical evidence must somehow affirmatively show a worsened condition. Here, Dr. Olson's reports do not meet that standard. On the contrary, Dr. Olson's later reports indicate that claimant's fractures had healed and that his spasm had resolved. Therefore, on this record, I agree that claimant has not proven his aggravation claim.

August 27, 1999 Cite as 51 Van Natta 1463 (1999)

In the Matter of the Compensation of
THOMAS P. PANICH, Claimant
WCB Case No. 98-09865
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Charles L. Lisle, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that upheld the self-insured employer's denial of his injury claim for a cervical and thoracic condition. On review, the issue is compensability.

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

Claimant argues that the ALJ should have deferred to the opinion of his treating physician, Dr. Pettigrew, instead of Dr. Thompson. He contends that Dr. Thompson's opinion is not persuasive because he changed his opinion without explanation. We disagree.

To begin, we agree with the ALJ's conclusion that claimant's symptoms from the August 1997 injury had not resolved at the time of his May 12, 1998 injury. Although Dr. Carvalho found that claimant was medically stationary on April 6, 1998, she noted that his neck, mid back and left shoulder pain continued to be at a "7-8 level of pain." (Ex. 21). On April 20, 1998, Dr. Pettigrew reported that claimant's neck, mid-back and left shoulder were "very sore" and stiff. (Ex. 20). Based on these chart notes, we are not persuaded by Dr. Pettigrew's later opinion that the first injury had "resolved" and was "dormant." (Ex. 51-1).

Drs. Zivin and Thompson examined claimant on behalf of the employer. They noted that claimant was quite evasive in his answers and claimant indicated he had difficulty remembering things. (Exs. 47-2, -3). They found that claimant had sustained a mild thoracic strain on May 12, 1998, although they noted that was based primarily on the history given by claimant. (Ex. 47-7). They explained:

> "Based on [claimant's] history that he gave us, it would appear that he had sustained a distinctly new injury in May of 1998, *i.e.*, this was primarily thoracic spine. However, in looking at the history given to his treating physician, he was complaining of neck pain similar to that which he had been complaining of previously.
>
> "There is a serious question, therefore, as to whether or not the ongoing complaints after May were not related to the previous incident and just ongoing symptoms. Certainly, the diagnoses that were made by Dr. Verzosa and Dr. Pettigrew involved the neck as well as the thoracic spine, and these were the same areas of complaint following the previous injury.
>
> "Certainly, the degenerative disc changes at C5, 6 could very well have played a significant role in the causation of his symptoms. The apparent evasiveness that was noted during the interview, one would have to have some question about the veracity of his history." (Ex. 47-7, -8).

In a later concurrence opinion with the employer's attorney, Dr. Thompson agreed that at the time of his examination, claimant had given him the impression he had suffered few, if any, residual symptoms and limitations from the August 1997 injury. (Ex. 52-2). Dr. Thompson agreed that claimant's veracity was "paramount" in his earlier conclusion that claimant had sustained a distinctly new injury in May 1998. (Ex. 52-3). After further review of Dr. Pettigrew's chart notes, Dr. Thompson understood that claimant had been treated for symptoms from the 1997 injury on March 25, 1998, April 14 and 20, 1998 and had complained of neck and mid-back stiffness. (*Id.*) Dr. Thompson agreed that the continued treatment of claimant's mid-back through April 20, 1998, considered in light of his similar complaints of mid-back pain and stiffness due to a "new injury," was vital in determining causation. (*Id.*) After considering the chart notes, as well as his earlier concerns about claimant's evasiveness, Dr. Thompson agreed that, to the extent that claimant sustained an injury on May 12, 1998, it was a symptomatic exacerbation of the preexisting condition from the 1997 injury. (Exs. 52-3, -4). Dr. Thompson agreed that claimant's preexisting condition from the August 1997 injury was the major contributing cause of his disablity and need for treatment in May 1998. (Ex. 52-3).

Although Dr. Thompson's later medical opinion on causation differed in part from his earlier report on causation, we find his change of opinion to be reasonable in light of his consideration of Dr. Pettigrew's chart notes. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive). Dr. Thompson had previously expressed concerns about claimant's evasiveness. Moreover, we are persuaded by Dr. Thompson's opinion because it is well-reasoned and based on an accurate and complete history. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). Although claimant continues to rely on Dr. Zivin's opinion, we do not find his opinion persuasive because there is no evidence he had an opportunity to review the additional chart notes from Dr. Pettigrew. We agree with the ALJ that claimant has failed to sustain his burden of proving compensability of his cervical and thoracic conditions.

ORDER

The ALJ's order dated April 6, 1999 is affirmed.

In the Matter of the Compensation of
RICK D. BLANK, Claimant
WCB Case No. 98-06757
ORDER ON REVIEW
Roger Wallingford, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's injury claim for a cervical condition; and (2) awarded an assessed fee of $4,250. 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.

After considering the factors set forth in OAR 438-015-0010(4), the ALJ awarded a $4,250 assessed attorney fee under ORS 656.386(1). In doing so, he noted that the attorneys had traveled to Baker City.

SAIF argues that the attorney fee is excessive, considering the factors set forth in the rule. In addition, SAIF contends that the ALJ erred in including a factor for travel. Claimant contends that the fee was reasonable. For the following reasons, we agree with claimant.

Travel time to a hearing or deposition represents hours of legal services rendered on behalf of a party, and that time is considered in awarding a reasonable attorney fee. *See Rollin R. Bradford*, 50 Van Natta 33 (1998) (travel *time* but not travel *costs* may considered in awarding an assessed fee). Thus, the ALJ could consider travel time in making a determination of an appropriate assessed fee.[1]

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. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The disputed issue at hearing was the compensability of claimant's cervical condition. The record contains 56 exhibits. The hearing lasted approximately 1 hour, but was conducted in a remote location. Claimant was the only witness and the transcript was approximately 13 pages long. There were no depositions, but claimant's counsel did obtain a litigation report that was important in deciding the case. (Ex. 56). Closing arguments were given by telephone and lasted 20 minutes. The case involved issues of average medical and legal complexity, as compared with compensability issues generally presented to the Board's Hearings Division for resolution. The value of the claim and the benefits secured are average. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,250 is a reasonable attorney fee for services at the hearings level in this case. We reach this conclusion because, while the value of the interest involved was average and the proceedings were not particularly complex, the time devoted to the compensability issue (as represented by the record and considering that claimant's attorney traveled to a remote hearing site) was significant. In addition, because of the conflicting medical evidence, there was a significant risk that claimant's counsel might go uncompensated. Accordingly, we affirm the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

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[1] We note, however, that claimant's attorney did not submit a statement of services specifying the amount of travel time to Baker City.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issue on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated April 8, 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
BRENDA M. BROOKS, Claimant
Own Motion No. 98-0214M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
John C. DeWenter, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's March 30, 1999 Notice of Closure which closed her claim with an award of temporary disability compensation from June 17, 1998 through September 2, 1998. SAIF declared claimant medically stationary as of March 19, 1999. Claimant does not contend that SAIF's closure was premature. Rather, claimant contends that she is entitled to additional temporary disability compensation until she became medically stationary.

Claimant is substantively entitled to temporary disability benefits if the record establishes that she was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992).

On June 17, 1998, claimant underwent L3-4 and L4-5 laminectomies and an L3 to L5 fusion. In a September 3, 1998 medical status report, Dr. Matteri, claimant's treating physician, indicated that claimant was able to "work," but also established a lifting restriction. In a December 17, 1998 letter to SAIF, Dr. Matteri noted that claimant had "returned to baby-sitting," but felt that claimant would not be able to return to her job at injury. He indicated that he expected to send claimant for a physical capacities evaluation at the six month mark in hopes of being able to close her claim at that time.

In January 1999, Dr. Matteri authored a chart noted wherein he opined that claimant was "neither stationary nor ratable and there is no change in her work status." He also indicated that he was sending claimant for physical capacities evaluation for claim closure. In a March 19, 1999 concurrence report, Dr. Matteri opined that claimant was medically stationary as of March 19, 1999.

Here, although Dr. Matteri indicated that claimant could "work" on September 3, 1998, he modified his work release to indicate that claimant was released to return to work with restrictions. He also indicated in his December 1998 report, that claimant could not return to her regular job, although she had returned to baby-sitting, a job she performed on a part-time basis. We interpret Dr. Matteri's opinion, espoused in his December 1998 report, to indicate that claimant was not released to regular work, but rather to the part-time baby-sitting job which complied with his work restrictions.

On this record, claimant has established that she was disabled due to her compensable injury until March 19, 1999, and, thus, entitled to temporary disability benefits until that time. *See Frank L Bush*, 48 Van Natta 1748 (1996). Therefore, we modify SAIF's Notice of Closure to award claimant temporary disability compensation, less time worked, from September 3, 1998 through March 19, 1999.

Accordingly, we modify SAIF's March 19, 1999 Notice of Closure to award claimant additional temporary disability compensation from September 3, 1998 through March 19, 1999 (less time worked) when she became medically stationary. The March 19, 1999 Notice of Closure is affirmed in all other respects.

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.

August 31, 1999 Cite as 51 Van Natta 1467 (1999)

In the Matter of the Compensation of
PATRICK WHITFORD, Claimant
WCB Case No. C991992
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Ernest M. Jenks, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

On August 19, 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 consideration due claimant is $*712.50* and the total due claimant's attorney is $*237.50*. The body of the CDA, (page 2), provides a total consideration of $950. However, page 3 provides that "[o]ut of the above consideration, claimant's attorney shall receive an attorney fee of $*950*. It is evident the reference on page 3 of the CDA to an attorney fee of "$*950*" was a typographical error.[1] Accordingly, we interpret the agreement as providing for a total consideration of $950, $712.50 payable to claimant and $237.50 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 $237.50, 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.

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[1] We note that a $237.50 attorney fee from total proceeds of $950 is consistent with OAR 438-015-0052(1).

In the Matter of the Compensation of
GLENN S. REUTER, Claimant
Own Motion No. 98-0391M
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable acute traumatic cervical and lumbosacral strain/sprain. Claimant's aggravation rights expired on March 5, 1987. The insurer opposes authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; and (3) the insurer is not responsible for the current condition.

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

Claimant currently resides out of the State of Oregon. Subsequent to his initial submission the insurer made several attempts to contact claimant in order to obtain recent medical records which would enable it to process his request for reopening of his claim under ORS 656.278. However, inquiries sent to the address claimant initially provided, was returned as undeliverable. The insurer submitted its recommendation to deny reopening on the basis that it had no information on which to process claimant's request.

Following the insurer's submission, claimant sent us a letter requesting an update on his request for own motion relief. He provided a different address. On February 11 and March 11, 1999, writing to claimant at his new address, we requested his response to the insurer's contentions.

Claimant responded to our inquiry and submitted several documents from various physicians which outline his physical and mental complaints and treatment. The insurer responded to claimant's submissions, contending that the documents submitted do not demonstrate a need for surgery and/or inpatient hospitalization.

Claimant's position was once again sought regarding the insurer's contentions. Claimant responded to our inquiry and stated that "I was never heal [sic] and recived [sic] improper care in the past and my injuries are not getting any better and I did not recived [sic] any kind of psychological care from the accident in [the] past to [sic]."

Although claimant may have some issues regarding the past handling of his claim and the possibility of consequential psychological conditions relating to his accepted injury, those are issues that are beyond the scope of our authority pursuant to ORS 656.278.

Because claimant's aggravation rights have expired on his 1990 compensable injury with the insurer, this claim is within our sole jurisdiction in our own motion authority. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988). Furthermore, the legislature has provided strict limitations on the Board's own motion authority. Pursuant to ORS 656.278(1)(a),[1] where a compensable injury worsens requiring surgery or hospitalization, "the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery[.]" Thus, by statute, a worker is not entitled to temporary disability compensation until his or her compensable condition has worsened requiring surgery or hospitalization and he or she actually undergoes the surgery or hospitalization.

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[1] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

Claimant contends that his compensable condition has never healed properly and he requires further medical treatment. But, claimant presents no medical evidence to support the contention that he requires surgery. Therefore, the record does not establish the necessary prerequisite to have claimant's own motion claim reopened for temporary disability benefits, *i.e.*, claimant's compensable condition has not required surgery or hospitalization. For that reason, we are not authorized to reopen claimant's claim for payment of temporary disability benefits.

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

IT IS SO ORDERED.

August 31, 1999 Cite as 51 Van Natta 1469 (1999)

In the Matter of the Compensation of
RODNEY SULLIVAN, Claimant
Own Motion No. 96-0269M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On May 28, 1999, we issued an Own Motion Order which dismissed a 1999 request for temporary disability compensation for claimant's compensable left knee condition because the claim remained opened as a result of a June 11, 1996 Own Motion Order. Claimant is now seeking penalties for the SAIF Corporation's untimely delay in reinstating his temporary disability benefits when his condition worsened requiring surgery.

On June 16, 1999, in order to allow sufficient time to consider claimant's motion for penalties, we directed the SAIF Corporation to file a response to the motion within 14 days of the date of the letter. We also advised claimant that he would be allowed 14 days from the mailing date of SAIF's submission to file a reply. Having received the parties' positions, we proceed with our review.

On June 11, 1996, we issued an Own Motion Order authorizing the provision of temporary disability compensation beginning the date claimant was hospitalized for surgery. In that order, we directed that when claimant was medically stationary, SAIF should close the claim pursuant to OAR 438-012-0055. At the time of the more recent request for reopening, we found that the record did not establish that the previously "reopened" claim had been closed pursuant to OAR 438-012-0055 and concluded that the claim remained in open status.

Penalties

Claimant seeks penalties 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).

In support of its position, SAIF contends that it did not timely pay temporary disability benefits because there had been a "change in [claimant's] employment status since the Order of June 11, 1996." SAIF further contends that it requested reconsideration of the June 11, 1996 Order, but that said request was denied.

We have previously determined that 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); *Brian Lutz*, 50 Van Natta 1421 (1998); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996).

Here, claimant's 1985 claim is in open status, and as a result of our order reopening the claim, temporary disability was due upon claimant's undergoing surgery or inpatient hospitalization. Since, SAIF did not close the claim pursuant to our rules and our June 11, 1996 order, when claimant worsened requiring surgery in February 1999, SAIF was obligated to begin time loss payments until claimant met the necessary criteria to close his claim. OAR 438-012-0055.

SAIF's reliance on a change in claimant's employment status is misplaced. The present issue is not whether the claim should have been reopened. Were that the case, claimant would be required to satisfy the requirements of ORS 656.278(1). Rather, at issue, is claimant's procedural entitlement to temporary disability when a claim has reopened and not closed.

Our June 11, 1996 Own Motion Order directed SAIF to commence payment of temporary disability compensation when claimant was hospitalized for the proposed surgery. Claimant underwent surgery on February 19, 1999. SAIF was obligated to commence the payment of temporary disability compensation within 14 days from the date claimant entered the hospital for surgery, *i.e.* March 5, 1999. SAIF did not commence timeloss payments until May 20, 1999. SAIF's reason ("change in [claimant's] employment") for failing to timely comply with our June 11, 1996 order did not provide it with a legitimate doubt regarding its liability to pay claimant compensation as granted by our order. Consequently, we find its failure to pay temporary disability benefits was unreasonable.

Therefore, under ORS 656.262(11)(a), we assess a 25 percent penalty of the temporary disability benefits paid by SAIF on May 20, 1999 (when it fully paid the then-current benefits authorized by our June 11, 1996 order).

IT IS SO ORDERED.

In the Matter of the Compensation of
LEONARD R. TERRIBLE, Claimant
WCB Case No. 97-04381
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Claimant requests reconsideration of our August 6, 1999 order that set aside the insurer's denial of claimant's occupational disease claim for a stress-related mental disorder and awarded an assessed fee of $6,500. Claimant seeks an increase in our attorney fee award to $26,250.

In order to consider this matter, we withdraw our August 6, 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.

In the Matter of the Compensation of
TERRI L. WALKER, Claimant
WCB Case Nos. 99-01197, 98-04931 & 98-07796
ORDER OF DISMISSAL
Robert J. Guarrasi, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Liberty Northwest Insurance Corp. (Liberty) requested review of Administrative Law Judge (ALJ) Hoguet's June 14, 1999 order. Claimant has moved to dismiss. We dismiss.

FINDINGS OF FACT

The hearing before the ALJ included three WCB numbers, with correspondingly different carriers and injury dates. Only responsibility was litigated. On June 14, 1999, the ALJ issued an order that upheld the denials of Hartford Insurance Co. (Hartford) and Safeco Insurance Co. (Safeco). The order also set aside Liberty's denial.

On June 29, 1999, the Board received correspondence from Liberty requesting review of "Judge Gary Thye's Order dated June 4, 1999." The letter referred to "Terri Walker" as the claimant and WCB case numbers 98-07796, 99-01197.

On June 30, 1999, the Board mailed a computer-generated letter acknowledging the request for review. Copies of the letter were sent to claimant, claimant's attorney, Safeco, Liberty, Hartford, counsel for those carriers, and the employers, Goodwill Industries and East Side Plating Company.

On August 4, 1999, the Board received claimant's motion to dismiss the request for review.

CONCLUSIONS OF LAW AND OPINION

Claimant alleges several grounds in support of the motion to dismiss. Claimant first notes that Liberty did not serve Goodwill Industries, Safeco, or Safeco's counsel on "appeal WCB case 9804931." Claimant also contends that ALJ Hoguet's June 14, 1999 order was not "properly appealed" because Liberty referred to an order from Judge Thye dated June 4, 1999.

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

Under ORS 656.295(1), the request for review "of an order of an Administrative Law Judge need only state that the party requests a review of the order." We have previously stated that our authority to review an ALJ's order "necessarily includes determining the order to which the [party's] appeal was directed[.]" *Dorothy I. Adams*, 48 Van Natta 2190, 2191 (1996).

For example, in *John J. Dronkers*, 50 Van Natta 954 (1998), the claimant filed a request for review that included the claimant's name, "a November 26, 1997 Opinion and Order, the employer, the claims processing agent, and the employer's attorney of record." The request for review, however, did not identify the ALJ and referred to incorrect case and claim numbers. In determining that the request for review was nevertheless valid, we reasoned that only one case involved the claimant's claim and a November 26, 1997 Opinion and Order. Thus, we concluded that the missing or inaccurate information was "not fatal" to the claimant's appeal. *Accord Dorothy I. Adams*, 48 Van Natta at 2191 (request for review valid even though contained inaccurate WCB number because "the ALJ's order issued on May 7, 1996 was clearly the subject of the employer request for review" and, thus, inaccurate WCB number was "not fatal to its appeal").

Based on these cases, in deciding whether the party has requested review of the ALJ's order, we look to whether the request provides sufficient accurate information to properly identify the appealed Opinion and Order. That is, if the request for review allows the Board to identify an order that corresponds with an existing Opinion and Order, then we find the request for review sufficient.

Here, the request for review contained incorrect references to the ALJ and the date of the order. We find such information essential to properly identifying the order sought to be appealed.[1] Although the request did provide claimant's name and some WCB numbers, as we have stated numerous times, our appellate authority is based on appealed ALJ orders, not WCB case numbers. *E.g., Dorothy I. Adams*, 48 Van Natta at 2191. Thus, by failing to name the correct ALJ and date of the order, we conclude that Liberty failed to successfully request review of ALJ Hoguet's June 14, 1999 order.

Accordingly, based on the foregoing reasoning, Liberty's request for Board review is dismissed.

IT IS SO ORDERED.

[1] In this regard, we find this case distinguishable from *John J. Dronkers* because, unlike *Dronkers*, this request for review presented the Board with deciding whether Liberty intended to appeal the claim for "Terri Walker" or Judge Thye's June 4, 1999 order. In other words, we find that Judge Hoguet's June 14, 1999 order was not "clearly the subject" of Liberty's request for review.

In the Matter of the Compensation of
WILLIAM D. WILDER, Claimant
Own Motion No. 66-0405M
OWN MOTION ORDER
Peter O. Hansen, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for medical benefits relating to his compensable February 22, 1961 injury claim. SAIF recommends against the payment of the requested benefits, (*i.e.* right carpal tunnel release), on the ground that the medical evidence does not establish a clear relationship of the requested medical services to the compensable injury. However, SAIF requests reopening 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 February 22, 1961 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).

Claimant responded to SAIF's submission and indicated the requested medical services are a direct sequelae of his 1961 right wrist injury. However, claimant does not provide any medical documentation to support his contention. Inasmuch as the record is insufficiently developed to make a compensability determination, we issue the following order.

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. After it obtains its medical file review, SAIF is directed to supplement the record with a copy of the report as well as its amended own motion recommendation. Finally, by this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS L. WILSON, Claimant
WCB Case Nos. 98-10045, 98-10044 & 98-0459M
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Nike, Inc., a self-insured employer, requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its responsibility denial of claimant's bilateral carpal tunnel syndrome; and (2) upheld the SAIF Corporation's responsibility denial of the same condition. On review, the issue is responsibility. We Reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change.[1] In the second paragraph on page 2, we change the third sentence to read: "Within a few months after working at Nike, claimant's symptoms diminished and were not causing him significant problems. (Tr. 12)."

CONCLUSIONS OF LAW AND OPINION

In early 1992, claimant began working for J-Ran, SAIF's insured, as a computer cable installer. (Ex. 1). He did not have any wrist pain before working at J-Ran. (Tr. 17). Claimant's work at J-Ran involved extensive use of the hands and wrists, cutting and pulling cable. In approximately April 1992, claimant began having problems with his hands and fingers. (Ex. 3-1). He sought treatment from Dr. Hudson, who diagnosed carpal tunnel syndrome (CTS). (*Id.*) Nerver conduction studies showed mild bilateral CTS. (Ex. 4, 5). Claimant was treated conservatively and by August 1992, Dr. Hudson reported a significant resolution of his symptoms. (Ex. 3, 5). SAIF accepted disabling bilateral CTS. (Ex. 7). The claim was closed on December 31, 1992 without an award of permanent disability. (Ex. 10).

Claimant left his employment with J-Ran on August 21, 1992 and began working for Nike. (Ex. 8). Claimant initially worked as a network engineer, which involved designing networks, performing installation work on computer equipment and managing network operating systems. (Tr. 9). His work was hand intensive and he performed computer keyboarding and reassembling computer systems. (Tr. 9). After four years, claimant was promoted to a managerial position at Nike and his keyboard work increased. (Tr. 9-10, 14). His physical work on computer components was reduced. (Tr. 10, 14). In his current position, he worked with the computer keyboard 50 percent of the time. (Tr. 10, 14).

Within a few months after working at Nike, claimant's CTS symptoms diminished and were not causing him significant problems. (Tr. 12). Claimant testified that he was symptom-free for a year or two, but then the symptoms returned slowly. (Tr. 9,13).

In November 1997, claimant sought treatment for increasing numbness and pain in his wrists from Mr. Chapman, physician's assistant. (Ex. 11). Dr. Hudson examined claimant on January 28, 1998 and reported that claimant's symptoms flared while working on a computer. (Ex. 12). On August 5, 1998, Dr. Madey recommended surgery. (Ex. 13). Dr. Madey became claimant's attending physician. (Ex. 14). Electrodiagnostic studies showed that claimant had severe bilateral CTS. (Ex. 16). Dr. Madey performed a right carpal tunnel release on December 17, 1998 and a left carpal tunnel release on January 19, 1999. (Exs. 21A, 24A).

SAIF, on behalf of J-Ran, and Nike both denied responsibility for claimant's bilateral CTS. (Ex. 18, 19B). The ALJ found that the medical evidence established that claimant's work at Nike had worsened his CTS condition and, therefore, Nike was now responsible.

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[1] We modify the ALJ's order to note that Exhibit 23A was also admitted in evidence.

Nike argues that the ALJ erred in requiring only a showing claimant's work at Nike was the major contributing cause of the worsening and not of the entire combined condition as well. Nike contends that SAIF remains responsible for claimant's bilateral CTS.

SAIF accepted claimant's bilateral CTS condition in 1992. SAIF remains "responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1). Thus, responsibility remains with SAIF, as the carrier with an accepted claim for bilateral CTS, unless the record establishes that claimant has sustained a new occupational disease involving the same condition. To establish a new occupational disease, the record must establish that claimant's employment conditions with Nike were the major contributing cause of the combined condition and pathological worsening of his disease. *See* ORS 656.802(2)(b); *Pamela T. Smith*, 50 Van Natta 2162 (1998).

SAIF relies in part on the opinion of Dr. Hudson to establish that responsibility for claimant's CTS condition shifts to Nike. Dr. Hudson treated claimant in 1992, when he was initially diagnosed with CTS. (Exs. 3, 9). He has examined claimant on one occasion since 1992. On January 28, 1998, he reported that claimant's CTS condition flared when he worked on the computer. (Ex. 12). Dr. Hudson again diagnosed CTS and recommended conservative treatment, but he noted claimant was considering surgery. (*Id.*)

In a later concurrence letter from Nike's attorney, Dr. Hudson agreed that claimant's CTS had never completely resolved and his current treatment was directly related to the CTS diagnosed in 1992. (Ex. 17-1, -2). Dr. Hudson also agreed that claimant's work at J-Ran was a "significant contributor" to the development of CTS. (*Id.*) He opined that the major contributing cause for the "onset of injury" was the J-Ran job. (Ex. 17-3). On the other hand, he believed that the major contributing cause for the "exacerbation" was claimant's current job. (*Id.*)

We construe Dr. Hudson's opinion that claimant's current work at Nike was the major contributing cause for the "exacerbation" to mean that his work at Nike was the major contributing cause of the worsening of his CTS condition. We do not agree with SAIF's assertion that Dr. Hudson said the major contributing cause of the current condition was the work at Nike. Thus, although Dr. Hudson believed that claimant's work at Nike was the major contributing cause of the *worsening* of his CTS condition, his opinion does not establish that the work at Nike was also the major contributing cause of the combined condition as required by ORS 656.802(2)(b). Dr. Hudson's opinion is not sufficient to establish that claimant's work with Nike was the major contributing cause of the combined condition *and* pathological worsening of his disease.

Similarly, Dr. Madey's opinion does not meet the requisite burden of proof to shift responsibility. Dr. Madey began treating claimant in August 1998 and he later performed right and left carpal tunnel releases. On August 5, 1998, Dr. Madey said that claimant had one year in the past five where his wrists had not bothered him. (Ex. 13). On September 23, 1998, Dr. Madey reported that claimant's bilateral CTS had worsened since December 1992. (Ex. 15A). He noted that claimant had been diagnosed with CTS in 1992 and he felt that claimant's "present employment may contribute to his condition but is not the major contributing cause." (Ex. 15A).

In a later concurrence letter from Nike's attorney, Dr. Madey agreed that claimant's CTS had not resolved since 1992 and he felt that claimant's current treatment was directly related to the CTS diagnosed in 1992. (Ex. 23A-1). Dr. Madey agreed that the force involved in claimant's job with J-Ran was the major contributing cause in the development of CTS. (Ex. 23A-2). He believed that the major cause of the CTS was the work at J-Ran and the major cause of the current worsening was the work at Nike. (*Id.*) In a January 18, 1999 report, Dr. Madey said that claimant had a pathological worsening of the CTS condition since 1992. (Ex. 24). He explained:

> "I think that [claimant's] current worsened condition is primarily caused by, *i.e.*, 51% or more his current job doing computer work. This is a clarification of my letter from September 23, 1998, in which I said that his present condition was primarily caused by the events prior to 1992, however, the way the letter is phrased, it appears you want to know what has contributed to the worsening of his condition. I believe the primary cause of worsening of his condition is his primary current employment." (*Id.*)

At most, Dr. Madey's opinion supports the conclusion that claimant's work at Nike was the major contributing cause of a pathological worsening of his CTS condition. His opinion, however, does not establish that claimant's work at Nike was the major contributing cause of the combined CTS condition, particularly in light of his earlier statement that claimant's "present employment [at Nike] may contribute to his condition but is not the major contributing cause." (Ex. 15A). In any event, even if we construe Dr. Madey's January 18, 1999 letter to mean that claimant's work at Nike was the major contributing cause of his combined condition, his opinion is not persuasive because he did not explain his change of opinion. *See Kelso v. City of Salem,* 87 Or App 630 (1987).

SAIF also relies on the opinion of Dr. Denekas, who performed a record review. He found that claimant's CTS had pathologically worsened since 1992. (Ex. 20-3). He reported that the "only data we have regarding this patient in regard to his activities is that he uses a computer, by your report 80% of the time at work." (*Id.*) Dr. Denekas concluded that claimant's pathological worsening of CTS was related to the work activities with his computer. (Ex. 20-4). In a later report, he said that the majority of claimant's work was with a computer and that activity was sufficient to lead to a pathological worsening of CTS. (Ex. 25-1). Dr. Denekas concluded that claimant's work at Nike with his use of computers was the major contributing cause of the combined condition and pathological worsening of the CTS. (Ex. 25-2).

Dr. Denekas is the only physician to opine that claimant's work at Nike was the major contributing cause of the combined CTS condition. Nevertheless, we are not persuaded by his opinion because he did not demonstrate an adequate understanding of claimant's work activities at Nike. He said that the "only data" he had was that claimant worked with a computer 80 percent of the time. (Ex. 20-3). Moreover, Dr. Denekas had an inaccurate understanding of the amount of computer work claimant performed. Claimant testified that he spent about 30 to 40 percent of his time at the computer keyboard during his first job at Nike and spent about 50 percent of the time at the keyboard since his promotion. (Tr. 14). . Although SAIF asserts that the record shows that claimant performed hand intensive work at Nike, there is no evidence that Dr. Denekas was aware of that fact. We are not persuaded by Dr. Denekas' opinion because it lacks adequate explanation. In addition, we note that he performed a records review and did not examine or treat claimant.

The only other medical opinion on causation does not support shifting responsibility to Nike. Dr. Laycoe found that the most plausible explanation for claimant's increased symptoms was the natural progression of his carpal tunnel condition. (Ex. 27-4). Dr. Laycoe did not believe that claimant's light work at Nike was the major contributing cause of a pathological worsening or his combined condition. (Ex. 27-3).

In sum, the record does not establish that claimant's later employment conditions at Nike were the major contributing cause of the combined condition and pathological worsening of his bilateral CTS condition. Therefore, under ORS 656.308(1), responsibility for claimant's CTS condition remains with SAIF.

Claimant submitted a respondent's brief on review. We note that compensability was not litigated at hearing and there is no evidence that claimant's compensation was at risk of disallowance or reduction. Moreover, claimant's temporary total disability rates would be the same under either claim. Under such circumstances claimant's compensation was not at risk of disallowance or reduction. *Dale I. Hargadine,* 51 Van Natta 428 (1999); *Oliver E. Pritchard,* 50 Van Natta 202 (1998) (compensation at risk on Board review when temporary disability rate under the claimant's claim with the appealing carrier is greater than the rate of the responding carrier); *John H. Kirkpatrick,* 47 Van Natta 2105 (1995) (compensation not at risk under ORS 656.382(2) for purposes of responsibility appeal when the claimant's temporary disability rate was the same under both claims. Accordingly, claimant's attorney is not entitled to an attorney fee for services on Board review. *See* ORS 656.382(2).

ORDER

The ALJ's order dated march 31, 1999 is reversed. SAIF's denial is set aside and the claim remanded to SAIF for processing according to law. Nike's denial is reinstated and upheld. SAIF is responsible for payment of the ALJ's $2,500 attorney fee award.

In the Matter of the Compensation of
ROGER S. KLINE, Claimant
WCB Case No. 98-09496
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of claimant's aggravation claim. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

Claimant, age 55, sustained a low back injury when he tripped over a bucket of water in a janitor's closet on July 8, 1994. (Exs. 24, 25). Dr. Rabie noted minor degenerative abnormalities in claimant's back and diagnosed his injury as a low back strain. (Exs. 29, 30). SAIF accepted a disabling low back strain. (Ex. 31).

On March 12, 1996, after litigation, the following additional conditions were found compensable: right hip pain, pelvic pain, groin pain, and right testicle pain. (Ex. 46). The claim was closed by an October 7, 1997 Notice of Closure that awarded 28 percent scheduled permanent disability for the right leg and 33 percent unscheduled permanent disability for the low back. (Ex. 63). A March 6, 1998 Order on Reconsideration reduced the scheduled permanent disability award to 15 percent and increased the unscheduled permanent disability award to 45 percent. (Ex. 77).

Claimant continued treatment with his now attending osteopathic physician, Dr. Heatherington, for low back, right hip, right groin and testicle pain. On August 5, 1998, Heatherington noted that claimant's low back pain was "severe," and the pain in right groin and testicle were "worse." He also noted that the hip pain had extended into the right leg and, occasionally, the foot. (Ex. 87). On August 19, 1998, Heatherington submitted a Notice of Claim for Aggravation. (Ex. 88). On December 1, 1998, SAIF denied the aggravation claim. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that there was no medical evidence establishing that any of claimant's accepted conditions had pathologically worsened, or that claimant's symptoms had worsened to such an extent that a physician concludes that the condition itself had pathologically worsened. On review, claimant argues that he has established the aggravation of his accepted July 1994 injury.

In order to prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition. ORS 656.273(1). In *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997), the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. The court held that proof of a pathological worsening is required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. *Id.*

Here, SAIF accepted a low back strain, right hip pain, pelvic pain, groin pain, and right testicle pain. An Order on Reconsideration dated March 6, 1998 awarded 15 percent scheduled permanent disability for his right hip condition and 45 percent unscheduled permanent disability for his low back condition. (Ex. 77). Claimant relies on the opinion of Dr. Heatherington, as well as his own testimony, to establish an "actual worsening" of his compensable conditions.

Claimant and his wife each testified that his pain has progressively worsened and that he is limited in his ability to sit or perform tasks that he was able to do a year before, and he testified that he has fallen on occasions because of the pain in his back and right leg. (Tr. 11 through 22 and 25 through 27). Nevertheless, because this matter presents a complex medical question, claimant's lay testimony is of limited persuasive value. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

Claimant relies on Dr. Heatherington's September 9, 1998 and February 10, 1999 reports to support an "actual worsening." On September 9, 1998, Heatherington reported that claimant had had an increase in low back and right buttocks muscle spasm on December 22, 1997, which became persistently worse and continued into the present. (Ex. 90). However, when asked the specific question whether claimant experienced an actual worsening of his low back strain/right hip pain/pelvic pain/groin pain and/or right testicular pain since the time of the March 1998 award, Heatherington hedged his reply, stating: "Subjectively he seems to be worse, objectively his limitations are not significantly changed." (Ex. 103). Explaining the factors leading to his conclusion, Heatherington stated: "He's relating his complaints and comments his wife has mentioned about his irritability and reduced activity at home." (*Id.*)

However, Heatherington's opinion that claimant's limitations have not objectively changed in any significant way since the prior award, as well as his characterization of claimant's complaints about reduced activity as "subjective," is not sufficient to establish that claimant's compensable conditions have pathologically worsened or that his symptoms had increased to the point that it can be said, based upon the conclusion of a medical expert, that the compensable conditions have pathologically worsened. *See SAIF v. Walker*, 145 Or App at 305; *compare Edward M. January*, 49 Van Natta 1477, *on recon* 49 Van Natta 1915 (1997) (treating physician agreed that the claimant's increased symptoms represented a worsening of the compensable lumbar strain). Moreover, there is no other opinion in the record that could be interpreted as supporting claimant's aggravation claim. (*See* Exs. 86, 92, 96, 104).

We find that Dr. Heatherington's report that claimant had increased pain and muscle spasm is not sufficient to establish an "actual worsening" of the compensable conditions. Therefore, we conclude that claimant has not established a compensable aggravation claim under ORS 656.273(1).

ORDER

The ALJ's order dated April 16, 1999 is affirmed.

In the Matter of the Compensation of
JENNIFER L. POTTER, Claimant
WCB Case No. 98-08753
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that reduced claimant's scheduled permanent disability award for loss of use or function for the right forearm (wrist) from 49 percent (73.5 degrees), as awarded by Order on Reconsideration, to 18 percent (27 degrees). On review, the issue is extent of scheduled permanent disability.

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

With her brief, claimant has attached an article from a medical textbook. Claimant requests that we take judicial notice of the article "to show the sequela affect [sic]of wrist trauma." (Appellant's brief, pg. 2). However, in a similar case, we declined to take administrative notice on the ground that the submission was offered to establish facts which the insurer had been given no opportunity to contest, cross-examine or refute. *See Piedad Zararte*, 41 Van Natta 2372 (1989) (Board declined to take official notice of an article from a medical textbook); *Groshong v. Montgomery Ward Co.*, 73 Or App 403, 408 (1985). Additionally, in this case, the article submitted by claimant was not part of the evidentiary record and there has been no showing that the article could not have been obtained and submitted with due diligence at the hearing. *See Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986). Accordingly, we deny claimant's request to take notice of the attached medical article.

Alternatively, we conclude that, even if we did consider the article submitted by claimant on review, it would not change the outcome of this case. Therefore, we affirm the order of the ALJ.

ORDER

The ALJ's order dated April 5, 1999 is affirmed.

In the Matter of the Compensation of
DARRELL L. KREIER, Claimant
WCB Case No. 98-04029
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) awarded temporary total disability (TTD) benefits for the period from October 21, 1997, through November 10, 1997; and (2) assessed a penalty for the insurer's allegedly unreasonable failure to pay TTD benefits for that period. On review, the issues are entitlement to TTD benefits and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, supplementation, and summary. We do not adopt the ALJ's ultimate findings of fact.

On December 15, 1995, claimant injured his right shoulder while performing his job as a truck driver. The insurer accepted a disabling right shoulder strain. (Ex. 21). Following this injury, claimant was released to and performed light duty work. The insurer paid claimant temporary partial disability (TPD) benefits from December 21, 1995 through July 9, 1997. (Ex. 69, Tr. 4-6).

On July 10, 1997, claimant underwent right shoulder surgery. As a result, claimant was unable to work from July 10, 1997 through July 20, 1997. Dr. Puziss, attending physician, released claimant to modified work as of July 21, 1997, and continued those modified work limitations until November 10, 1997, when he declared claimant medically stationary and released him to his regular truck driving job. (Exs. 58-2, 60, 61-2, 62, 63-1).

No modified work was provided claimant after July 20, 1997; therefore, the insurer paid claimant TTD from July 10, 1997 through October 20, 1997. (Ex. 69, Tr. 7-10).

On or about October 21, 1997, the employer presented claimant with a written job offer with the title "Portland Appointment Manager." (Ex. 1). This job offer generally described the duties required and the pay, but did not indicate the time or date the job was to begin, nor did it state whether the attending physician had approved the job. Claimant was concerned that he could not remain in the union if he accepted a "manager" position, so he crossed out the word "Manager" in the job title, signed the job offer form, and indicated that he accepted the job duties, job description, and pay rate, but did not accept the job title. (*Id.*).

The employer interpreted this response as declining the job offer. The insurer began paying claimant TPD as of October 21, 1997, the date of the job offer, and continued paying TPD through November 10, 1997, the date claimant was declared medically stationary and released to regular work. (Tr. 7-10).

On January 30, 1998, the insurer issued a Notice of Closure, declaring claimant medically stationary as of November 10, 1997. Claimant was awarded unscheduled permanent disability and temporary disability as follows: TPD for the period from December 21, 1995 through July 9, 1997; TTD for the period from July 10, 1997 through July 20, 1997; and TPD for the period from July 21, 1997 through November 10, 1997. (Ex. 68). Claimant requested reconsideration.

On April 23, 1998, an Order on Reconsideration affirmed the medically stationary date, reduced claimant's unscheduled permanent disability award and awarded temporary disability "beginning Dec. 18, 1996[1] and ending November 10, 1997, less time worked." (Ex. 77-4 (footnote added)). The Order on Reconsideration noted that, "[i]n accordance with OAR 436-030-0036(1), only the beginning and ending dates of 'authorized' temporary disability for this open period of the claim are shown in this Order." (Ex. 77-2). Claimant requested a hearing on the reconsideration order.

CONCLUSIONS OF LAW AND OPINION

Relying on ORS 656.268(3) and OAR 436-060-0030(5), and applying procedural time loss principles, the ALJ found that the insurer did not meet the necessary requirements to terminate TTD and begin paying TPD. Therefore, the ALJ concluded that claimant was entitled to continue receiving TTD from October 21, 1997 through November 10, 1997. Furthermore, because none of the events in ORS 656.268(3) occurred during this period that would permit the insurer to stop paying TTD and begin paying TPD, the ALJ concluded that the insurer acted unreasonably in doing so and assessed a penalty of 25 percent of the amounts due during that period. ORS 656.262(11)(a). We disagree.

Temporary Disability Benefits

Adjusting for the parties' stipulation regarding a typographical error in the April 23, 1998 Order on Reconsideration, that order awarded, *inter alia,* temporary disability beginning December 21, 1995 and ending November 10, 1997, less time worked. (Ex. 77-4). At hearing and on review, the sole issue regarding temporary disability is whether claimant is entitled to TTD (rather than the TPD awarded and paid) for the period from October 21, 1997 through November 10, 1997. (Tr. 7-10).

In arguing for their respective positions, the parties rely on the distinction between procedural and substantive time loss.[2] Under the facts of this case, we need not determine whether principles of procedural or substantive time loss control because claimant's claim fails under either category.

After correcting for the typographical error in the reconsideration order, that order awards temporary disability for the same period as the January 30, 1998 Notice of Closure. Claimant does not argue otherwise. Therefore, that portion of the temporary disability award that covers the period in question provides that claimant is awarded *TPD* for the period from July 21, 1997 through November 10, 1997. This corresponds to Dr. Puziss' release to modified work from July 21, 1997 through November 10, 1997, when he declared claimant medically stationary and released him to his regular truck driving job. Although the insurer actually paid TTD for the period from July 21, 1997 through October 20, 1997, *TPD,* not *TTD,* was awarded for this period. Claimant does not dispute that portion of the award. Instead, claimant's only argument is that he is entitled to TTD for the period from October 21, 1997 through November 10, 1997.

Thus, contrary to the parties' arguments, the issue is not whether the insurer was entitled to reduce claimant's TTD to TPD. Instead, because claimant was entitled to TPD from July 21, 1997

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[1] At hearing, the parties stipulated that the Order on Reconsideration contained a typographical error in that: (1) claimant's entitlement to temporary disability began on *December 21, 1995,* not December 18, 1996; and (2) the insurer claimed no overpayment for that period. (Tr. 4-6; Ex. 80).

[2] "Procedural" temporary disability benefits are those benefits payable under ORS 656.268 while an accepted claim is in open status. *SAIF v. Taylor,* 126 Or App 658 (1994). A worker's entitlement to "substantive" temporary disability benefits 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. ORS 656.210; 656.212; *Santos v. Caryall Transport,* 152 Or App 322 (1998); *Lebanon Plywood v. Seiber,* 113 Or App 651 (1992) (Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date). Claimant has the burden of proving the extent of disability resulting from the work injury. ORS 656.266.

through October 20, 1997, the issue is whether claimant is entitled to have the *TPD* increased to *TTD* for the period from October 21, 1997 through November 10, 1997.[3] Under the facts of this case, we find that claimant is not entitled to that increase.

Under principles of procedural entitlement to temporary disability, the administrative rules provide the circumstances under which TPD is to be discontinued. Specifically, OAR 436-060-0030(9) provides:

> "(9) When the worker's disability is partial only and temporary in character, temporary partial disability compensation pursuant to ORS 656.212 shall continue until:
>
> "(a) The attending physician verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;
>
> "(b) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268;
>
> "(c) The compensation has been paid for an aggregate period of two years * * * ; or
>
> "(d) The compensation is lawfully suspended, withheld or terminated for any other reason."

Thus, only if the attending physician verifies that the worker is no longer able to perform the modified job and is again temporarily totally disabled can TPD be increased to TTD on a procedural basis. OAR 436-060-0030(9)(a). As noted above, this did not occur. Instead, Dr. Puziss continued to release claimant to modified work through November 10, 1997, when he declared him medically stationary. Therefore, if the temporary disability issue is analyzed on a procedural basis, claimant remains entitled to only TPD for the period from October 21, 1997 through November 10, 1997.[4]

A substantive analysis produces the same result. Here, the only evidence regarding claimant's disability status during the period in question is provided by Dr. Puziss, who released claimant to modified work during that period. (Exs. 58-2, 60, 61-2, 62, 63-1).

Accordingly, the preponderance of the evidence establishes that claimant is entitled to TPD for the period from October 21, 1997 through November 10, 1997. There is no dispute that the insurer timely paid this TPD. Therefore, there is no basis to award a penalty under ORS 656.262(11)(a) for unreasonable resistance to payment of compensation. Consequently, we reverse the ALJ's penalty assessment.

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[3] We respectfully submit that the dissent misses this important distinction. Like the parties, the dissent misstates the issue as whether claimant is entitled to *continue* receiving TTD for the period in question. But that statement of the issue does not comport with the facts of this case. Although the insurer paid TTD during the period in question, claimant was actually awarded TPD for that period. Thus, the issue is whether claimant is entitled to have his TPD *increased* to TTD for the period in question. For that reason, the dissent's reliance on ORS 656.268(3), which provides the requirements for *continuing* TTD, and its analysis regarding *Atchley v. GTE Metal Erectors*, 149 Or App 581, 585, *rev den* 326 Or 133 (1997), simply do not apply to the facts of this case.

The dissent also asserts that, because the insurer actually *paid TTD* for the period from July 21, 1997 through October 20, 1997, it is not important that claimant does not challenge the award of TPD for that period. We disagree. After all, it is the *award* of temporary disability benefits made by the Notice of Closure and affirmed by the Order on Reconsideration that is being challenged, and claimant explicitly challenges only that portion of the award covering the period from October 21, 1997 through November 10, 1997. After the unchallenged portion of the award becomes final, it could become subject to an offset for overpayment against future benefits, if any. ORS 656.268(15)(a). In fact, here, the Notice of Closure provided that overpaid benefits may be deducted from current or future benefits in accordance with ORS 656.268. (Ex. 68-1). More important to our reasoning in the present case is the fact that the unchallenged portion of the award ended with an award of *TPD*; therefore, the issue becomes whether claimant is entitled to have this TPD increased to TTD. As explained below, we find that he is not.

[4] In reaching this conclusion, we assume, without deciding, that the "procedural" temporary disability analysis can apply after claim closure. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999).

ORDER

The ALJ's order dated September 1, 1998 is reversed in part and affirmed in part. Those portions of the order that awarded TTD for the period from October 21, 1997 through November 10, 1997, granted an "out-of-compensation" attorney fee based on that award, and assessed a penalty regarding the insurer's allegedly unreasonable failure to pay TTD for that period are reversed. The remainder of the order is affirmed.

Board Member Biehl dissenting.

I agree with the ALJ that claimant is entitled to receive TTD benefits from October 21, 1997 through November 10, 1997, although my reasoning differs from that of the ALJ. Because the majority finds otherwise, I respectfully dissent.

Temporary Disability Benefits

Adjusting for the parties' stipulation regarding a typographical error, the April 23, 1998 Order on Reconsideration awarded, *inter alia,* temporary disability beginning December 21, 1995 and ending November 10, 1997, less time worked. (Ex. 77-4). At hearing and on review, the sole issue regarding temporary disability is whether claimant is entitled to TTD (rather than the TPD awarded and paid) for the period from October 21, 1997 through November 10, 1997. (Tr. 7-10).

The insurer argues that, because claimant's claim has been closed, he is entitled to substantive temporary disability benefits, which are due for those periods during which claimant was disabled due to the compensable injury, prior to becoming medically stationary. Applying this substantive entitlement test, the insurer argues that claimant is not entitled to TTD benefits for the period of October 21, 1997 to November 10, 1997, because he was released to light duty on July 21, 1997, and on October 21, 1997, he refused the employer's "regular" job offer, which the insurer contends was within his physical restrictions. Claimant counters that he is entitled to TTD for the period in question under either procedural or substantive temporary disability rules. In making their arguments, both the insurer and claimant mix the concepts of substantive and procedural temporary disability. For the following reasons, I find that claimant is substantively entitled to TTD for the period of October 21, 1997 to November 10, 1997.

The distinction between procedural and substantive temporary disability has been addressed in two ways. First, it has been addressed in terms of the timing of when benefits are due during the life of a claim. In this regard, "procedural" temporary disability benefits have been defined as those benefits payable under ORS 656.268 while an accepted claim is in open status. *SAIF v. Taylor,* 126 Or App 658 (1994). On the other hand, "substantive" temporary disability benefits have been defined as those benefits that are determined on claim closure and established 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. ORS 656.210; 656.212; *Santos v. Caryall Transport,* 152 Or App 322 (1998).

Second, this distinction has been addressed in terms of the source of a worker's entitlement to temporary disability benefits. In this regard, the court has held that "the general distinction between a substantive and procedural entitlement is that a substantive benefit is one that is made explicit and unconditional by statute, while a procedural benefit is conditional, arising solely from the vagaries of claim processing." *Atchley v. GTE Metal Erectors,* 149 Or App at 585. The court in *Atchley* also summarized its decision in *Vega v. Express Services,* 144 Or App 602, 607 (1996), as holding generally, and "in accord with *Lebanon Plywood* [*v. Seiber,* 113 Or App 651 (1992)],[1] and its progeny, that a substantive entitlement must derive from explicit statutory authority." *Atchley,* 149 Or App at 586 n.2 (footnote added).

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[1] In *Seiber,* the employer sought review of orders of the Board that required it to pay temporary disability benefits during the period between the point at which the claimant became medically stationary and the issuance of a determination order. 113 Or App at 653. The court reversed the Board, reasoning:

> "Substantively, the worker's entitlement to temporary benefits ends on the medically stationary date. Because of delays in processing, the actual payment of temporary benefits continues until the determination order is issued. That delay results in an overpayment of temporary benefits that the employer is entitled to recoup by deduction from any permanent disability compensation awarded. * * * If processing delay does not result in overpayment, the Board has no authority to impose one." *Id.* at 654.

Although the parties' arguments focus on the first definition, I find that the facts of this case fit more closely within the second definition, as summarized in *Atchley*. In *Atchley*, after the claimant had been declared medically stationary and his claim closed, he entered an authorized training program (ATP). As a result, the insurer reinstituted payment of TTD benefits. Subsequently, the claimant completed the ATP, and the insurer suspended payment of TTD benefits at that time. Several months later, a Determination Order issued that: (1) reclosed the claim; (2) affirmed the initial medically stationary date; and (3) awarded TTD benefits only for the duration of the ATP. The claimant requested a hearing, contending that the insurer was required to continue payment of TTD benefits until termination was authorized by ORS 656.268(9). Citing *Lebanon Plywood v. Seiber*, the ALJ declined to award further temporary disability benefits. The Board affirmed the ALJ's decision.

On appeal, the court reversed, finding that the claimant was substantively entitled to the temporary disability benefits in question. In reaching this decision, the court found the case before it analogous to *Roseburg Forest Products v. McDonald*, 116 Or App 448 (1992), and *Anodizing, Inc. v. Heath*, 129 Or App 352 (1994). In those cases, the court held that, under *former* ORS 656.313(1) and ORS 656.313(1)(a)(A), respectively, the claimants were unconditionally entitled to temporary disability benefits accruing during the pendency of their appeals, regardless of the outcome of those appeals. *Roseburg Forest Products*, 116 Or App at 452; *Anodizing, Inc.*, 129 Or App at 357. In addition, the *Anodizing* court explained that, unlike *Lebanon Plywood*, no overpayment of benefits would result under the statute because the carrier would not be entitled to recoup any benefits paid pending appeal, even if it ultimately prevailed on appeal.

Applying this reasoning, the *Atchley* court found that the claimant's entitlement to temporary disability benefits was substantive because, unlike *Lebanon Plywood*, but similar to *Roseburg Forest Products* and *Anodizing, Inc.*, it derived from an explicit entitlement in *former* OAR 436-60-040(3), which required the insurer to continue to pay temporary disability benefits during the period between completion of a training program and issuance of a redetermination order if certain requirements were met. The court found that the claimant met those requirements and, therefore, was substantively entitled to temporary disability benefits until issuance of the redetermination order. Because claimant was substantively entitled to those benefits, the court held that the Board erred in applying *Lebanon Plywood* and in denying those benefits.

I find *Atchley* analogous to the present case. Here, the requirements for terminating TTD benefits are specified by statute and rule. Specifically, ORS 656.268(3) provides:

> "(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." (Emphasis added).

OAR 436-060-0030(5) applies ORS 656.268(3)(c) and provides:

> "(5) An 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 an injured worker fails to begin wage earning employment pursuant to ORS 656.268(3)(c), under the following conditions:

"(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;

"(b) The attending physician agrees the employment appears to be within the worker's capabilities; and

"(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

Thus, ORS 656.268(3) specifically and unconditionally *requires TTD benefits to continue* until one of the listed conditions occurs. The majority misses this important point. Claimant underwent surgery on July 10, 1997. As a result, he was unable to work from July 10, 1997 through July 20, 1997. During that period, the insurer paid claimant *TTD* benefits. On July 21, 1997, Dr. Puziss released claimant to modified work. But, no modified work was offered claimant; therefore, the insurer continued paying *TTD* from July 21, 1997 through October 20, 1997.[2] Then, on or about October 21, 1997, the insurer presented claimant with an offer of "modified work." As of that date, the insurer reduced claimant's *TTD* to *TPD*. Thus, contrary to the majority's characterization of the issue, the issue is whether the insurer was entitled to reduce claimant's benefits from *TTD* (which it was paying as of October 20, 1997) to *TPD*.[3] That is, in fact, what the insurer did; the question is whether it was entitled to make such a reduction. Based on the reasoning that follows, I conclude that it was not so entitled.

This is similar to the requirement provided by rule in *Atchley* that the insurer continue paying temporary disability benefits during the period between completion of an ATP and issuance of a redetermination order if certain requirements were met. It is also similar to the statutes applied in *Roseburg Forest Products* and *Anodizing, Inc.* that required a carrier to pay benefits accruing during the pendency of an appeal. In those cases the court determined that the statutory or administrative requirements resulted in the claimants being substantively entitled to the temporary disability benefits in question. In addition, unlike *Lebanon Plywood*, a statutorily created substantive entitlement to TTD benefits does not result in an overpayment of benefits. In other words, if a claimant is entitled to benefits by statute, it necessarily follows that payment of such benefits would not result in an overpayment; thus, a carrier would not be entitled to recoup any benefits paid in accordance with the statute. The same analysis applies to the present case.

Accordingly, I would find that claimant is substantively entitled to TTD benefits for the period in question, *i.e.*, from October 21, 1997 through November 10, 1997,[4] unless one of the conditions listed in

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[2] The majority makes much of the fact that claimant does not dispute the Notice of Closure/Order on Reconsideration award of *TPD* from July 21, 1997 through October 20, 1997, but the insurer *paid* claimant *TTD* for this period, so there was nothing for claimant to dispute. Furthermore, as explained below, payment of a statutorily required benefit does not result in an overpayment; therefore, the majority's discussion of an offset for an "overpayment" is not relevant.

[3] In any event, even if the majority's focus on entitlement to increasing TPD to TTD is correct, its reliance on OAR 436-060-0030(9)(a) is misplaced. OAR 436-060-0030(9)(a) provides that TPD pursuant to ORS 656.212 shall continue until "[t]he attending physician verifies that the worker can no longer perform the modified job and is again temporarily totally disabled." Clearly, this rule contemplates a worker actually *performing* a modified *job* before the rule comes into play. During the period in question, however, claimant did not *perform* any modified *job*. Therefore, by its terms, OAR 436-060-0030(9)(a) does not apply to the facts of this case.

[4] Actually, substantive entitlement to TTD benefits extends from July 10, 1997 through November 10, 1997. But, as explained above, because the insurer paid TTD from July 10, 1997 through October 20, 1997, only the period from October 21, 1997 through November 10, 1997 is at issue before the Board.

ORS 656.268(3), as applied in OAR 436-060-0030(5), occurred to terminate that entitlement.[5] On this record, I find that none of the listed conditions occurred.

During the relevant period, claimant did not return to regular or modified work. In addition, he was not released by his attending physician to return to regular work; instead, he was only released to light duty. Thus, the requirements to permit termination of TTD benefits under either ORS 656.268(3)(a) or (b) were not satisfied. The insurer argues that the job offer it made on or about October 21, 1997 was an offer for a "regular" job and, as such, does not fall within the requirements of ORS 656.268(3)(c) and OAR 436-060-0030(5)(c). In the alternative, the insurer argues that the offer was for a "modified" job and satisfies the requirements of ORS 656.268(3)(c) and OAR 436-060-0030(5)(c) and, thus, entitled it to stop paying TTD benefits. I disagree with both arguments.

The employer presented claimant with a written job offer with the title "Portland Appointment Manager." (Ex. 1). This job offer generally described the duties required and the pay, but did not indicate the time or date the job was to begin, nor did it state whether the attending physician had approved the job. Claimant was concerned that he could not remain in the union if he accepted a "manager" position, so he crossed out the word "Manager" in the job title, signed the job offer form, and indicated that he accepted the job duties, job description, and pay rate, but did not accept the job title. (*Id.*).

First, the insurer contends that this job offer constituted an offer for a "regular," newly created job, not a "modified" job for an injured worker. Therefore, the insurer contends, ORS 656.268(3)(c) does not apply to this job offer. I need not decide whether a "regular" job offer is outside the scope of ORS 656.268(3)(c) because I find that the job offer was for modified work. Specifically, the job offer asked claimant to indicate whether he accepted "the light-duty position offered by [the employer]." *Id.* Thus, the language of the job offer itself refutes the insurer's contentions. Therefore, ORS 656.268(3)(c) and OAR 436-060-0030(5)(c) apply to this job offer.

In the alternative, the insurer contends that claimant's objection to the "Manager" job title and subsequent failure to start working at this job constitutes a failure to begin work under ORS 656.268(3)(c), which would permit it to stop paying TTD benefits. But, as noted above, this job offer provided no beginning date and time. Therefore, the insurer can hardly rely on the fact that claimant failed to start work to contend that he declined the job offer. In any event, the job offer itself failed to meet the requirements of OAR 436-060-0030(5)(c). In this regard, the rule requires the job offer to provide the beginning date and time. In addition, it requires the job offer to provide notice that "the attending physician has found the job to be within the worker's capabilities." *Id.* Here, the job offer failed to abide by these requirements. *See Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986) (strict compliance with the requirements of *former* OAR 436-60-030(5) is required; substantial compliance is not enough). Accordingly, the insurer did not meet the requirements under ORS 656.268(3), as applied in OAR 436-060-0030(5), that would permit it to stop paying TTD benefits.

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[5] I find additional support for my finding of substantive entitlement to TTD under the circumstances of this case in the legislature's policy statement regarding the objectives of the Workers' Compensation Law. In this regard, the legislature declared the objectives of the Law to be, in part:

> "(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;
>
> "(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable;
>
> "(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable[.]" ORS 656.012(2)(a) through (c).

The majority's holding results in claimant's TTD being terminated even though the insurer did not follow the requirements necessary to terminate that compensation. Such a holding simply does not abide by the legislature's policy in enacting the Workers' Compensation Law.

Finally, I find no basis under ORS 656.268(3)(d) to terminate TTD benefits. In this regard, claimant's attending physician continued to release claimant only to modified work duty during the period in question. Therefore, for the reasons explained above, claimant remained substantively entitled to TTD benefits under ORS 656.268(3) for the period in question, *i.e.*, from October 21, 1997 through November 10, 1997.[6]

Penalties

I would adopt the ALJ's reasoning and conclusions on the penalty issue. At hearing and on review, the insurer argued that the employer's October 21, 1997 job offer met the requirements of ORS 656.268(3) and OAR 436-60-030(5)(c); thus, entitling it to stop paying TTD benefits as of October 21, 1997.

Although I have found that ORS 656.268(3) provides a substantive entitlement to TTD benefits, which presents a new interpretation of that statute, the basis for terminating TTD benefits remains unchanged. In other words, the insurer must meet the requirements of ORS 656.268(3) and OAR 436-060-0030(5)(c). Those requirements are well-defined. As explained above, the insurer's arguments that it met those requirements are not well taken. Therefore, I would find that claimant is entitled to the penalty awarded by the ALJ under ORS 656.262(11)(a).

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[6] In reaching this decision, I acknowledge that the court has considered procedural and substantive entitlement to temporary disability benefits in light of the legislature's 1995 addition of ORS 656.262(4)(f), which provides a 14-day limitation on retroactive authorization of temporary disability benefits. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999). [The court noted that this statute has since been renumbered ORS 656.262(4)(g) and referred to it by its current number in its opinion; I do the same]. The majority in *Bundy* focused on the legislature's intent in enacting ORS 656.262(4)(g) and rejected the dissent's arguments regarding the distinction between substantive and procedural entitlement to temporary disability benefits. Specifically, the court found that the legislature intended that the 14-day limitation on retroactive authorization of temporary disability benefits in ORS 656.262(4)(g) provide "a limitation on all awards of temporary disability under ORS 656.268." *Id.* at 54. Thus, in disregarding any distinction between substantive and procedural entitlement to temporary disability benefits, the majority focused its analysis on the meaning of ORS 656.262(4)(g). Given this explicit limitation in the court's opinion, and given the fact that I, too, am limiting my analysis to interpreting a specific statute, I need not decide the effect, if any, the *Bundy* court's decision might have on the distinction between substantive and procedural entitlement to temporary disability benefits outside of ORS 656.262(4)(g).

In the Matter of the Compensation of
EDWARD HOLESTINE, Claimant
WCB Case No. C991995
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

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

The first page of the agreement provides that claimant has fully released "[P]enalties and Attorney Fees." However, in the body of the CDA (page 7, number 19), the agreement provides that "the terms of this Claims Disposition Agreement do not include: (1) attorneys' fees or penalties associated with any act, or failure to act, occurring only after the day the Board received this agreement and (2) attorney fees permitted or awarded by this agreement itself."

In interpreting a CDA, we generally rely on the more specific provisions in the body of the CDA regarding attorney fee and penalties, rather than the more general provisions on the first page of the CDA. *See Carol J. Mullins*, 51 Van Natta 198 (1999). In light of such circumstances, we interpret the parties' intention in the CDA to be that claimant fully releases all "non-medical service" benefits allowed by ORS 656.236, except for penalties and attorney fees for the processing of medical benefits and attorney fees allowed by the CDA itself. We conclude that the reference to a "full" release of benefits ("including Penalties and Attorney Fees"), on the first page of the CDA, to be a clerical error. By this order, we correct that error.

In conclusion, the agreement, as clarified and amended by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $6,875, 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.

In the Matter of the Compensation of
CHAD N. CARTER, Claimant
WCB Case Nos. 98-07109 & 98-06762
ORDER ON REVIEW
Geoffrey G. Wren, Claimant Attorney
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that awarded claimant's attorney an assessed fee of $2,500 for services in obtaining a rescission of its compensability denial of claimant's left shoulder impingement syndrome. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's attorney was instrumental in obtaining a rescission of the insurer's compensability denial of claimant's left impingement syndrome. Claimant's attorney requested an attorney fee of $3,232.55. The insurer agreed that claimant was entitled to a fee, but it argued that a fee of $3,232.55 was excessive. The ALJ found that a reasonable fee for claimant's attorney's prehearing services regarding the compensability issue was $2,500. The ALJ explained that he did not award the entire amount requested because the case was not particularly complex, claimant's attorney performed a moderate amount of legal work, the hours devoted to the work were slightly excessive, the $200 hourly rate was slightly excessive and paralegal time could not be factored into the overall attorney fee.

On review, the insurer argues that the $2,500 fee is excessive. The insurer contends that the case was "average at best" and it urges the Board to reduce the fee to $1,500 or less. On the other hand, claimant contends that the ALJ "struck a fair balance" and he asks us to affirm the ALJ's order.[1]

In *Schoch v. Leupold & Stevens*, 162 Or App 242 (1999), the claimant argued that the Board had abused its discretion when it reduced her attorney fee request by more than half. The claimant argued that nothing in the Board's order showed that either the time her counsel spent or his hourly rate was unreasonable. The claimant asserted that the fact that she had recovered $5,750 in a parallel proceeding did not justify the reduction imposed by the Board. The court found that it could not determine from the Board's order how it evaluated the various factors considered in arriving at a $3,000 fee. The court held that when either a claimant or an insurer submits a specific statement of services or a specific objection to a fee award, the Board must explain why its consideration of the various factors caused it to agree or disagree with the specific request or objection a party has presented.

We determine a reasonable attorney fee under OAR 438-015-0010(4) by considering 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 insurer denied compensability of claimant's left shoulder impingement syndrome on August 4, 1998 and September 1, 1998. (Exs. 5, 8). On August 26, 1998, claimant's attorney requested a hearing on the insurer's August 4, 1998 denial and "all denials." On March 24, 1999, a stipulation and order was approved in which the insurer agreed to rescind its denials and accept claimant's claim for left subacromial impingement syndrome. The parties agreed to submit the issue of a reasonable attorney fee to an ALJ.

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[1] We note that claimant has withdrawn his cross-request for review.

Claimant's attorney submitted a statement of services, a memorandum in support of the statement of services and his affidavit in support of the claim for attorney fees. Claimant's attorney asserted that he recorded his time spent on this case and tracked his time by using a computer billing program that bills time in tenths of an hour. Claimant's attorney requested a fee of $3,232.55, indicating that he had devoted 15.6 hours to the case at a rate of $200 per hour and his paralegal had devoted 1.5 hours at a rate of $75 per hour.

In reviewing the time devoted to this case, the insurer asserts that, at the time of the acceptance, there were 14 exhibits in the record, two of which were generated by claimant's attorney. The record presently has 23 exhibits, thirteen of which have been generated or submitted by claimant's attorney. In negotiating a settlement, claimant's attorney relied in part on two medical reports he submitted from Dr. Topper. There were no depositions. Claimant's attorney requested a hearing on the insurer's August 4, 1998 denial and "all denials." In addition, claimant's attorney explained that he spent a substantial amount of time in negotiating a settlement.

As compared to typical compensability cases, the issue of claimant's left impingement syndrome was of average complexity. Because claimant's impingement syndrome 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. Claimant may receive compensation for medical services and temporary disability, as well as permanent disability. Claimant's attorney asserted that claimant may face the possibility of surgery. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. No frivolous issues or defenses were presented. Furthermore, given the contradictory medical opinions, there was a risk that claimant's counsel might go uncompensated if the parties had not settled the case.

The 15.6 hours devoted to the case by claimant's attorney's appears to be reasonable in light of the nature and complexity of the case. Claimant's attorney's affidavit of hours indicated that time was incurred before the stipulation was approved on March 24, 1999. Claimant's attorney's fee request also includes 1.5 hours of paralegal time at a $75 per hour. The insurer argued that the time devoted to the case by claimant's attorney's paralegal should not be considered in determining a fee. "Paralegal" time generally represents a cost incurred by an attorney in pursuing a matter on behalf of a party. *Patricia L. McVay*, 48 Van Natta 317, 318 n.1 (1996). Those costs are not directly considered as fees paid to an attorney. *See* OAR 438-015-0005(6). Nevertheless, to the extent the reference to "paralegal" time represents hours of research and investigation subject to supervision of an attorney, such efforts have been considered in evaluating a reasonable attorney fee. *Candace L. Spears*, 47 Van Natta 2393 n.1 (1995). Here, we interpret claimant's attorney's reference to "paralegal" services as time expended in research and investigation subject to his supervision. Consistent with *Spears*, in determining a reasonable attorney fee, we have also accorded limited significance to such hours.

The insurer agreed that claimant's attorney was an experienced practitioner who emphasized workers' compensation litigation, but the insurer objected to the rate of $200 per hour. The insurer's attorney asserted that rate was "well above" any billing rate of any workers' compensation attorney known to him. The insurer relied in part on information from the Department of Consumer and Business Services (DCBS), which indicated that the average fee awarded by Opinions and Orders in 1997 was $2,938, compared with an average stipulated fee of $1,319.[2]

With regard to the insurer's statistics, claimant's attorney argued below that those statistics included fees from all cases in Oregon, but the cost of practicing law in Portland, where he practices, is higher than elsewhere in the state. Claimant also asserted that the general risk of "claimant-side" practice has risen significantly in the past decade.

After reviewing the record and considering the factors in OAR 438-015-0010(4), we agree with the ALJ that $2,500 is a reasonable attorney fee in this case. In reaching this conclusion, we have particularly considered the time devoted to the issue (based on claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, the nature of the proceedings (a

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[2] The insurer submitted the reports from DCBS as evidence and those documents were considered without objection. *Compare Carrie Newton*, 50 Van Natta 1750, 1753, n. 1 (1998) (ALJ's use of a "2.5 multiplier" based "official records" from DCBS was inappropriate; there was no indication the records represented agency decisions or orders and, therefore, the documents were not subject to administrative notice).

pre-hearing rescission of a denial) and the risk that claimant's counsel may go uncompensated. In particular, we find that the 15.6 hours devoted to the case by claimant's attorney was comparable to those in cases of similar nature and complexity presented to this forum.[3] *See Eloy Cuellar*, 48 Van Natta 814 (1996) ($2,300 was a reasonable attorney fee for prehearing rescission when counsel devoted 15.5 hours, which included generating a medical report showing causation, and securing medical benefits that included surgery).

Because the only issue on review was the attorney fee award 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 regarding this issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated May 6, 1999 is affirmed.

[3] As discussed earlier, we have accorded limited significance to the 1.5 hours devoted to the case by claimant's attorney's paralegal. Similarly, because the statistics relied upon by the insurer are an average from 1997, we do not accord them much probative weight.

In the Matter of the Compensation of
LYNDA S. GEORGE, Claimant
WCB Case No. 99-00450
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld SAIF Corporation's denial 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" as supplemented below.

Attending physician Dr. Hubbard opined that "[claimant's] fall at work likely caused a contusion of her L5-S1 nerve root and subsequent refractory symptomatology." (Ex. 44).

CONCLUSIONS OF LAW AND OPINION

The medical evidence persuasively establishes that claimant has a degenerative condition in his low back that preexisted and combined with his October 1997 compensable low back injury. Therefore, claimant must prove that the compensable injury remains the major contributing cause of his disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B). Claimant has the burden to prove compensability. ORS 656.266.

The ALJ found Dr. Hubbard's opinion unpersuasive and insufficient to meet claimant's burden of affirmatively proving that the October 1997 compensable injury remained the major contributing cause of claimant's need for treatment for the combined condition. Consequently, the ALJ upheld SAIF's denial.

The only doctor to provide an opinion in support of claimant's claim is her attending physician, Dr. Hubbard. Relying on his opinion, claimant asserts that her condition is compensable because her compensable injury remains the major contributing cause of her combined condition. In support, claimant contends that Dr. Hubbard is a neurosurgeon and the only physician with a complete and accurate medical history. Therefore, claimant asserts that Dr. Hubbard's opinion is most persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986).

We generally defer to the conclusions of the attending physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons to do otherwise.

First, determining the major contributing cause of 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, 401 (1994). The fact that the work injury may have precipitated the worker's 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).

Dr. Hubbard did not weigh the relative contribution of claimant's preexisting degenerative changes or explain his rationale for naming the incident at work as the major cause. Rather, Dr. Hubbard opined that "[claimant's] fall at work likely caused a contusion of her L5-S1 nerve root and subsequent refractory symptomatology." (Ex. 44). We find that this explanation is no more than the "precipitating cause" analysis that was rejected in *Dietz v. Ramuda*, 130 Or App at 401.

Claimant accurately notes that the failure to use the "magic words" of "major contributing cause" is not necessarily determinative. *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). However, even when a treating physician has used "magic words," a combined or new condition will not necessarily be found compensable when the medical evidence does not support such a finding. *Susan K. Cox*, 51 Van Natta 36 (1999).

Here, Dr. Hubbard only states that the work-related injury *likely* caused the need for treatment, which does not establish with reasonable certainty that claimant's condition was causally connected to her work-related injury. *Gormley v. SAIF*, 52 Or App 1055 (1981) (worker must prove more than just possibility of causal connection between work-related injury and the need for treatment). Finally, Dr. Hubbard's opinion appears to be directed to the initial combination of claimant's preexisting condition and her compensable injury rather than the current relationship between her injury and the combined condition.

Based on the foregoing reasoning, we are not persuaded by Dr. Hubbard's opinion. Consequently, because no other physician supports claimant's contention that the October 1997 injury remained the major contributing cause of her current need for medical treatment for the combined condition, we agree with the ALJ's decision to uphold SAIF's denial.

ORDER

The ALJ's order dated May 10, 1999 is affirmed.

In the Matter of the Compensation of
MARK E. LANDON, Claimant
WCB Case No. 98-02810
ORDER OF ABATEMENT
Bryant, Emerson, et al, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

Claimant requests abatement and reconsideration of our August 11, 1999 Second Order of Dismissal that dismissed claimant's request for review on the ground that the request was not timely filed. Accompanying claimant's motion are affidavits from his counsel and counsel's staff.

In order to consider this matter, we withdraw our August 11, 1999 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHYLLIS J. WOODS, Claimant
WCB Case No. 96-02347
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Bock and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the Ultimate Findings of Fact. We briefly summarize the pertinent facts as follows:

Claimant compensably injured her low back in 1975. As a result of this injury, she underwent a laminectomy at L4-5, S1 and a spinal fusion L4-5 to sacrum in March 1977. Claimant became medically stationary in July 1979.

Claimant was relatively symptom free for 15 years. In December 1994, she experienced back pain for about a week. The problem resolved without medical treatment. Then, in June 1995, her back pain returned without any specific incident or trauma. When these symptoms did not improve, she sought treatment.

Claimant first saw Dr. Westermeyer, who diagnosed back strain superimposed on the previous surgery. In July 1995, Dr. Westermeyer referred claimant to Dr. Borman, who diagnosed chronic lumbar strain status post lumbar laminectomy and fusion. In October 1995, Dr. Westermeyer referred claimant to Dr. Grewe, who had treated her 18 years prior in connection with her back surgery.

In November 1995, Dr. Grewe performed a myelogram of the entire neural canal. He noted that claimant's principal medical problem was her diabetes. His myelogram findings were minimal, and included very mild scarring on the right at L3-4.

In a December 1995 letter to SAIF, Dr. Grewe opined that claimant's 1975 injury was not the major cause of her current condition and need for treatment. He concluded that she had degenerative disc disease at L3-4, diabetes and a history of anxiety attacks. Drs. Borman and Westermeyer also declined to relate claimant's current condition to her 1975 injury.

After SAIF denied claimant's current condition, Dr. Grewe reported that "the symptoms that might be arising from the bone donor site would be residuals from the bone donor site scar." He also noted that the first moveable joint above claimant's fused segments would experience increased stress, and concluded that there was a causal connection between her current condition and her 1975 injury.

Claimant continued to treat with Dr. Grewe. In June 1996, Dr. Grewe indicated that the source of claimant's pain was the cluneal nerve endings that developed amputation neuromas at the bone donor site on the left. In January 1997, Dr. Grewe again found pain around claimant's bone donor site. And in June 1997, Dr. Grewe reported that claimant's bone donor site pain was the result of the spinal fusion procedure and associated bone harvest.

In July 1998, claimant was evaluated by Dr. Rosenbaum at SAIF's request. Dr. Rosenbaum found no evidence of clinically significant neuroma formation in claimant's iliac donor crest site. He also found that her pain was not localized through this region and that she had no palpable abnormalities. Dr. Rosenbaum concluded that claimant's L3-4 degenerative disc disease was idiopathic or age related and that she did not need further medical care with regard to her low back symptoms.

In August 1998, Dr. Grewe characterized Dr. Rosenbaum's report as "by and large" accurate. Dr. Grewe also noted that the slow development of pathology above the fused segments is a common consequence of increased stress on the joint above a solid fusion. In addition, Dr. Grewe reported that when he originally saw claimant she had severe pain at the bone donor site, although the pain was currently being controlled with a H-wave stimulator.

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Grewe's later reports and opinions, the ALJ concluded that claimant had established the compensability of her current low back condition. On review, SAIF contends that the medical evidence is insufficient to sustain claimant's burden under ORS 656.005(7)(a)(A). Specifically, SAIF asserts that Dr. Grewe's opinion is inconsistent and lacking in analysis and therefore unpersuasive.[1] As set forth below, we agree with SAIF.

As a general rule, a medical expert's unexplained change of opinion is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987); *see also Theodore W. Lawpaugh*, 51 Van Natta 65 (1999). Here, as noted above, Dr. Grewe initially opined that claimant's 1975 injury was not the major cause of her current condition or need for treatment. (Ex. 53) He later reported that claimant's symptoms "might be" arising from the donor site scar. (Ex. 54-2). And, in June 1997, he affirmatively stated that claimant's bone donor site pain was the result of her spinal fusion and associated bone harvest. (Ex. 60C-1) But then, after reviewing Dr. Rosenbaum's July 1998 report (which concluded that claimant had idiopathic degenerative changes and no evidence of clinically significant neuroma formation in her iliac donor crest site), Dr. Grewe indicated that Dr. Rosenbaum's report was "by and large" accurate. (Ex. 62).

Because Dr. Grewe did not offer any explanation for his inconsistent opinions, we find his reports insufficient to sustain claimant's burden. Indeed, even if we were to conclude, as did the ALJ, that Dr. Grewe became more convinced over time of a causal connection between claimant's 1975 compensable injury and her current condition low back condition, he did not offer any rationale for his change of opinion. *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); *see also Yann You*, 49 Van Natta 602 (1998), *aff'd mem* 152 Or App 248 (1998) (doctor's opinion "as a whole" unpersuasive due to unexplained variations). Furthermore, to the extent Dr. Grewe couched his changed opinion in terms of possibility (*i.e.*, that the symptoms "might be" arising from the bone donor site) rather than probability, it remains insufficient to establish compensability. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet claimant's burden of proof).

In addition, as SAIF argues, Dr. Grewe did not adequately respond to Dr. Rosenbaum's conclusions that claimant had no evidence of neuroma foundation and that her subjective symptoms were likely due to idiopathic or age-related degenerative changes. For these reasons, we find that claimant has not established the compensability of her current low back condition.

ORDER

The ALJ's order dated April 16, 1999 is reversed. SAIF's denial of claimant's current low back condition is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

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[1] Dr. Grewe was the only treating or examining physician to relate claimant's current symptoms to her 1975 compensable injury. As noted above, both Dr. Westermeyer and Dr. Borman specifically declined to relate claimant's current complaints to her prior injury and surgery.

In the Matter of the Compensation of
PHYLLIS J. WOODS, Claimant
Own Motion No. 97-0169M
OWN MOTION ORDER
Westmoreland & Mundorff, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

The SAIF Corporation submitted a request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights on that claim expired on July 18, 1984. SAIF denied the compensability of and responsibility for claimant's current low back condition. Claimant requested a hearing. (WCB Case No. 96-02347). In addition, SAIF recommended against reopening on the grounds that: (1) it is not responsible for claimant's current condition; and (2) claimant was not in the work force at the time of disability.

By Opinion and Order dated December 13, 1996, Administrative Law Judge (ALJ) Spangler set aside SAIF's denial. SAIF requested Board review of ALJ Spangler's December 13, 1996 order. On January 8, 1998, we remanded to ALJ Spangler to reopen the record and take further evidence. *Phyllis J. Woods*, 50 Van Natta 39 (1998).

By an Order on Remand dated April 16, 1999, ALJ Spangler adhered to his prior order and directed SAIF to process claimant's current condition under his 1975 claim. SAIF requested Board review of ALJ Spangler's April 16, 1999 order, and in an order issued on today's date, we reversed ALJ Spangler's order and reinstated and affirmed SAIF's denial. Consequently, we address claimant's request for temporary disability compensation under ORS 656.278(1)(a).

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

Here, the current condition and ensuing medical treatment for which claimant requests own motion relief, remain in denied status. As a result, we are not authorized to grant claimant's request for own motion relief. *See Id.*

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

IT IS SO ORDERED.

In the Matter of the Compensation of
LORENZO SORIANO-GARCIA, Claimant
WCB Case No. 99-00809
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's injury claim for a laceration of his sigmoid colon. On review, the issue is compensability.

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

Claimant, an auto detailer, suffered a laceration of his sigmoid colon on November 19, 1998 after Mr. Garcia, a coworker, discharged a compressed air hose near claimant's rectum as he was bent over working on an auto. Approximately one hour before claimant's injury, claimant had discharged a compressed air hose 4 or 5 inches from the backside of Mr. Garcia.

The ALJ concluded that the employer had acquiesced in the horseplay of the workers. The ALJ reasoned that claimant had been an active participant in horseplay an hour before he was injured, but was not an active participant at the time he was injured and he was not aware that horseplay was occurring at that time. The ALJ concluded that the November 19, 1998 injury occurred in the course and scope of claimant's employment.

We write primarily to address the insurer's argument that the employer did not acquiesce in the horseplay of its workers. The insurer contends that Mr. Sanchez, the president of the company, was unaware of any significant amounts of horseplay, and none involving air hoses. The insurer asserts that, had the president known of such conduct, he would have put an immediate stop to it.

Under Oregon law, "an active participant or instigator in horseplay who is injured may not receive compensation unless the employer knew or should have known of and acquiesced in the behavior." *Kammerer v. United Parcel Service*, 136 Or App 200, 204 (1995); *see Stark v. State Industrial Acc. Com.*, 103 Or 80, 98 (1922) (employee killed when he engaged in horseplay with air hose was entitled to compensation because employer knew of horseplay and had no policy prohibiting it).. In *Kammerer*, the court explained:

> "The theory behind excluding active participants in horseplay from coverage is that, in engaging in the horseplay, the employee may have engaged in a 'voluntary stepping-aside from the employment.' *See* Arthur Larson, 1A *Larson's Workmen's Compensation Law* § 23.30, at 5-183 (1990). If a participant in horseplay is hurt and files a claim, then the employer's knowledge of and acquiescence in the horseplay become relevant. Where horseplay is common and the employer knows or should know of it and does nothing actively to discourage it, then an active participant in horseplay may recover. That is because an employer's decision to acquiesce in horseplay can reasonably be understood to make that activity an aspect of the work environment, such that an employee who engages in horseplay will *not* be understood to have voluntarily stepped aside from employment. *Brown [v. Liberty Northwest Ins. Co.*, 105 Or App 92, 95 (1990)] (citing *Stark*, 103 Or at 98)." *Kammerer*, 136 Or App at 204 (emphasis in original).

In the present case, even if we assume, without deciding, that claimant was an active participant in horseplay at the time he was injured, we agree with the ALJ's conclusion that the employer acquiesced in the horseplay of the workers.

Claimant said that he and his coworkers "used to play often" with the air hose prior to his injury. (Tr. 37). He testified that "[w]e all used to play" with the air hose. (Tr. 34). On the day he was injured, neither he nor Mr. Garcia were trying to hurt each other. (Tr. 36). They were just playing and did not realize the danger of the air hoses. (*Id.*) Claimant testified that the workers also played with towels and hit each other's legs, and put wax on each other's backs. (Tr. 37, 38). They played with plastic balls by throwing the balls and hitting each other. (Tr. 38). Claimant testified that Mr. Ramerez, his supervisor, did not tell him to stop doing these things until after he was injured. (Tr. 39). On the other hand, claimant agreed that Mr. Sanchez, the president of the company, did not want the employees to fool around on the job. (Tr. 46).

About two years ago, claimant and a coworker were wrestling and fell into a car. (Tr. 47). Claimant and the other coworker walked off the job after the wrestling incident. (Tr. 27-28, 31-32, 47, 67-68). Claimant left his employment for about 4 months, but was later reemployed. (Tr. 32, 47).

Mr. Ramerez testified that he had seen the workers play around on many occasions, except for the older workers. (Tr. 19, 20). He said that no one had been hurt in the horseplay until claimant was injured. (Tr. 21). Mr. Ramerez was aware that the workers often engaged in various forms of horseplay, including throwing sponges and towels at each other, putting wax on each other's backs and squirting each other with air hoses. (Tr. 20-26). Mr. Ramerez agreed, however, that Mr. Sanchez, the president of the company, told him the workers were not supposed to fool around. (Tr. 32).

Mr. Barranca, a coworker, agreed that he had seen workers squirt the air hose at others, throw sponges, snap towels and put wax on each other. (Tr. 56). He agreed that he was not paid to perform those activities. (Tr. 56, 57).

Mr. Sanchez, the president, testified that he did not consider fooling around with air hoses or other objects to be part of the job. (Tr. 65). During the time he worked in the shop as an auto detailer and manager, he had never seen employees playing with air hoses or squirting them at each other. (Tr. 63, 69). He noted, however, that until the last couple of years, the air hoses did not operate with a trigger and were not as likely to be used as a weapon. (Tr. 64). Mr. Sanchez had seen workers throwing objects or snapping towels a few times. (Tr. 63). He explained that if he had known the workers were fooling around, he would have discussed the matter with them. (Tr. 69).

An employer's acquiescence may be established by showing that the injurious activity was a "common practice or custom in the work place." *Clark v. U.S. Plywood*, 288 Or 255, 267 (1980). In *Stark v. State Industrial Acc. Com.*, the court found that the horseplay that the worker had engaged in, which consisted of shooting an air hose at a coworker, was commonplace where he worked. The court found the accident "was an incident of such employment by reason of the appliance used in the work, and the custom which prevailed of the employees, without the infraction of any enforced rule of the establishment, diverting the use of the air hose to sport." 103 Or at 98.

In the present case, we find that the horseplay activities were quite common and the employer acquiesced in such activities. There were no written rules prohibiting horseplay. Although Mr. Sanchez, the president, may not have known about the horseplay incidents and would have stopped them, we find that Mr. Ramerez, the direct supervisor of the workers, was aware of the horseplay

activities and did nothing to actively discourage them. Mr. Ramerez' testimony indicated that he participated in those activities. When he was asked about putting wax on others' backs, he responded: "Yeah, we -- sometimes we'd play." (Tr. 24). Even if Mr. Ramirez did not participate in the horseplay, we find no evidence that the employer was engaged in a program to keep horseplay activity under control. *See Benjamin L. Thornton, Jr.*, 46 Van Natta 2389 (1994); *compare Brown v. Liberty Northwest Ins. Co.*, 105 Or App at 94 (the employer had a program to keep horseplay under control and had not acquiesced in it). We conclude that the employer acquiesced in the horseplay activities.

In arguing there was no acquiescence, the insurer relies on the fact that Mr. Garcia was terminated for his role in the air hose incident. The insurer also contends that claimant would have been subject to discipline for the previous wrestling incident, had he not avoided the discipline by quitting his job. The discipline of Mr. Garcia did not take place until *after* claimant was injured. Furthermore, even if we assume that claimant would have been subject to discipline for the previous wrestling incident, that fact is not entitled to much probative weight because that incident took place nearly two years ago. We find no current evidence to establish that, prior to claimant's injury, management took any active, meaningful measures to end horseplay activities, including playing with the air hose. There is no persuasive evidence that any workers were disciplined or fired for any horseplay activities until after claimant was injured. We agree with the ALJ's conclusion that claimant was injured in the course and scope of employment.

We also address the insurer's argument that the injury is not compensable because it arose out of recreational or social activities engaged in primarily for his personal pleasure. Under ORS 656.005(7)(b)(B), a "compensable injury" does not include an "[i]njury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activity primarily for the worker's personal pleasure[."] The focus of the inquiry under ORS 656.005(7)(b)(B) is the primary purpose of the activity that causes the worker's injury. *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478, *rev den* 320 Or 453 (1994).

We agree with the ALJ that claimant's injury occurred while he was working on a car and was unaware of any recreational or social activity at that time. Furthermore, we are not persuaded that claimant's injury occurred "as the result of engaging in or performing" a recreational or social activity primarily for his personal pleasure. We acknowledge that approximately one hour before the injury, claimant had discharged a compressed air hose 4 or 5 inches from the backside of Mr. Garcia. As we discussed earlier, we find that the horseplay activities were customary in the work place and the employer acquiesced in such activities. Under these circumstances, even if we assume the activities in question constitute "recreational or social activity," we find that the activities had a close work nexus. We conclude that claimant's injury did not occur as the result of an activity primarily for his personal pleasure and, therefore, ORS 656.005(7)(b)(B) does not apply in this case.

Finally, we address the insurer's argument that claimant's injury is not compensable because it arose out of his active participation in an assault or combat. ORS 656.005(7)(b)(A) provides that an injury is not compensable if it is an "[i]injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties[.]" The statute excludes from compensability injuries from assaults (1) to an active participant in the assault and (2) when the assault is not connected to the job assignment and amounts to a deviation from customary duties. *Redman Industries, Inc. v. Lang*, 326 Or 32, 38 (1997). Unless both of those elements are met, the exclusion does not apply. *Id.*

We agree with the ALJ that the conduct at issue did not rise to the level of an assault or combat. Claimant testified that neither he nor Mr. Garcia were trying to hurt each other on the day he was injured. (Tr. 36). He said they were just playing and did not realize the danger of the air hoses. (*Id.*) There is no contrary evidence. As we discussed earlier, the horseplay activities, including playing with air hoses, were common and had been going on for some time. We find that the activities at issue in this case did not constitute "assaults or combats." We conclude that ORS 656.005(7)(b)(A) does not apply in this case.[1]

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[1] Alternatively, even if we assume that the conduct causing the injury was an "assault," we would find that it was connected to the job assignment. *See Donald Converse*, 50 Van Natta 1830 (1998), *aff'd mem* 160 Or App 700 (1999).

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

ORDER

The ALJ's order dated May 4, 1999 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
RASHELL A. TERRANOVA, Claimant
WCB Case No. 98-06699
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Reinisch, MacKenzie, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's occupational disease claim for a right trigger finger condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer in early December 1997 as a hostess in a restaurant. When claimant began her job, the restaurant cash register system was not computerized. She spent the first two weeks of her job in training for the hostess position. In this position, claimant seated patrons and gave them menus. She accepted payment for service at the cash register, which included running charge slips and making change. She also distributed tips to servers at the end of each shift. Claimant was also responsible for keeping a running account of the manner in which each check was paid and had to balance that accounting against the cash register tape at the end of each shift.

In the course of performing her job duties, claimant spent approximately 25 percent of her shift handwriting. When claimant was handwriting, she gripped the pen in such a manner that caused her right fourth finger to be curled into her palm. Claimant worked 84.5 hours in her first 12 days of employment and 72.25 hours in her second two-week period of employment. Thereafter, claimant's work shift was reduced to 25 to 30 hours per week.

After approximately one month on the job, claimant began experiencing pain in her right fourth finger. Thereafter, claimant's finger began "'sticking," first occasionally and then more frequently. Claimant was able to self-release and extend her finger when this occurred.

In February 1998, the restaurant changed over to a computerized system, which lessened claimant's handwriting duties.

On April 24, 1998, the employer's restaurant closed due to a fire. Although claimant was still an employee after that date, she performed no work activities. Sometime in May 1998, claimant reported finger complaints to a supervisor.

On June 1, 1998, claimant sought treatment for her finger symptoms from Dr. Hardiman, M.D. Dr. Hardiman diagnosed trigger finger and eventually recommended release surgery. On June 12, 1998, claimant filed an 801 Form asserting that her right trigger finger condition was causally related to her work activities with the employer.

By letter dated August 11, 1998, the self-insured employer denied claimant's claim for a right trigger finger condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's claim for a right trigger finger condition did not present a complex medical question. Then, based on claimant's testimony and the lack of contrary medical evidence, the ALJ concluded that claimant had established that her work activities with the employer were the major contributing cause of the right trigger finger condition. We disagree.

In order to establish that her right trigger finger condition is compensable as an occupational disease, claimant must show that her work activities with he employer were the major contributing cause of the claimed condition. ORS 656.802(2)(a). Where the claimed condition is of such a nature as to require skilled and professional persons to establish causation, expert medical evidence is necessary to meet the burden of proof. *See Madewell v. Salvation Army*, 49 Or App 713, 717 (1980).

In determining whether expert medical evidence is necessary, the court has enumerated the following relevant factors: (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. *Barnett v. SAIF*, 122 Or App 279, 283 (1993) (citing *Uris v. Compensation Department*, 247 Or 420, 426 (1993)).

Claimant attributes her right trigger finger condition to her writing duties undertaken in the first month of her employment. However, claimant did not perform those duties consistently throughout her work shift. (Tr. 32, 39). Rather, those duties comprised approximately 25 percent of her work shift. (*Id.*). In addition, although claimant's writing duties lessened in February 1998, when the restaurant became computerized, claimant's symptoms did not lessen or abate. (Tr. 25). Similarly, although claimant was not working following the April 1998 fire, she did not report any symptoms to her supervisor until May 1998. (Tr. 14). Finally, claimant did not seek medical treatment until June 1, 1998, approximately 5 months after the onset of her symptoms. (Ex. 1). In this regard, claimant testified that her symptoms worsened even though she had not worked since April 24, 1998. (Tr. 21).

In light of the lengthy delay in reporting her symptoms and seeking medical treatment, as well as claimant's testimony that her symptoms worsened after she was no longer performing writing duties, the causal relationship between those duties and claimant's condition presents a complex medical question. The only medical opinion comes from Dr. Hardiman. Dr. Hardiman indicated that he did not believe two weeks of hand intensive duties could cause trigger finger. (Ex. 6). In addition, Dr. Hardiman indicated that he did not know whether claimant's work activities were the major contributing cause of claimant's trigger finger condition. (*Id.*).

Because there is no medical opinion establishing that claimant's work activities were the major contributing cause of her right trigger finger condition, claimant has failed her burden of proving that her occupational disease claim is compensable. Accordingly, the self-insured employer's denial must be upheld.

ORDER

The ALJ's order dated May 12, 1999 is reversed. The self-insured employer's denial, dated August 11, 1998, is reinstated and upheld.

In the Matter of the Compensation of
WILLIAM M. WHITFIELD, Claimant
WCB Case No. 99-00858
ORDER ON RECONSIDERATION
Heiling & Associates, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Claimant requests reconsideration of our August 18, 1999 Order on Review that adopted and affirmed Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the insurer's denial of his aggravation claim for a right great toe fracture condition; and (2) upheld the insurer's partial denial of his claim for a right great toe neuritis condition. In addition, we supplemented our order and explained why we rejected claimant's argument that, under the facts of this case, the doctrine of issue preclusion established a compensable aggravation claim, as a matter of law. On reconsideration, claimant makes this same argument, adding the contention that the "operative facts"/"factual basis" are the same in both the current aggravation claim and the prior claim regarding the medically stationary status of his claim. Having received the insurer's response and claimant's reply, we proceed with our reconsideration.

After further review of claimant's "issue preclusion" argument, we continue to reject it for the reasons explained in our prior order. Nevertheless, we write to address claimant's "operative facts"/"factual basis" analysis.

On March 3, 1998, claimant's right great toe was fractured when a front end loader bucket was lowered onto his foot. The insurer accepted this injury as a disabling fracture of the right great toe distal phalanx. (Ex. 3). On June 23, 1998, the insurer closed the claim by a Notice of Closure that declared claimant medically stationary as of June 1, 1998, and awarded only temporary disability. (Ex. 4). Subsequently, following litigation through the Board review level, it was finally determined that claimant's claim was not prematurely closed and claimant was not entitled to any permanent disability benefits.

Thereafter, claimant filed the aggravation claim that is the subject of the present case. Based on the above prior litigation, claimant argues that the doctrine of issue preclusion establishes a compensable aggravation claim. Specifically, on reconsideration, claimant argues that:

> "Since claimant was found to be medically stationary without [permanent] impairment on June 23, 1998, that is the benchmark for this case. 'Issue preclusion' prevents a further analysis of that judicially determined fact, regardless of contradictory evidence. Therefore, the only task in this case is to determine whether claimant's medical condition at the time of his claim for aggravation was different from what had previously been judicially determined." Motion for Reconsideration, page 2.

Claimant goes on to contend that "[t]he ultimate conclusions in this case are not the same as the ultimate conclusions in the first case, but the operative facts in this case are based squarely on the operative facts of the first case." *Id.* Finally, claimant contends that:

> "The rule of 'issue preclusion' compels us to abide by the operative facts in the first case, namely, that claimant was medically stationary without [permanent] impairment on June 23, 1998. On August 4, 1998, claimant's injury manifested objective pathology and disability. That difference is an aggravation, as a matter of law." *Id.*

We find several problems with claimant's argument. First, it does not apply the correct legal standard for establishing a compensable aggravation claim. ORS 656.273 provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

Thus, contrary to claimant's argument, he must do more than merely show that his "medical condition at the time of his claim for aggravation was different from what had previously been judicially determined." Instead, to prove a compensable aggravation, claimant must establish an "actual worsening" of the compensable condition since the last award of compensation. ORS 656.273(1). In *SAIF v. Walker*, 145 Or App 294, 305 (1996), *rev allowed* 325 Or 367 (1997), the court interpreted the "actual worsening" language in ORS 656.273(1) to require direct medical evidence that a condition has worsened. The court held that proof of a pathological worsening is required to prove an aggravation and that it is no longer permissible, as it was under the former law, to infer a worsened condition from evidence of increased symptoms alone. *Id.* Among other things, he must establish by medical evidence an "actual worsening" of the compensable condition. As we stated in our prior order, we adopt the ALJ's reasoning and conclusions that claimant failed to establish a compensable aggravation claim on the merits.

Another problem with claimant's argument is that, although arguing that the doctrine of "issue preclusion" resolves the aggravation issue in his favor, by using a "same operative facts" analysis, a concept that is dealt with in the doctrine of "claim preclusion," he appears to be relying on that doctrine, or at least mixing the doctrines of issue and claim preclusion. But "claim preclusion" clearly does not apply to the facts of this case.

Res judicata, or "preclusion by former adjudication," precludes relitigation of claims and issues that were previously adjudicated. *Drews v. EBI Companies*, 310 Or 134, 139 (1990); *North Clackamas School Dist. v. White*, 305 Or 48, *mod* 305 Or 468 (1988). The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. *White*, 305 Or at 53. Issue preclusion can apply to issues of either fact or law. *Drews*, 310 Or at 140. Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. *Million v. SAIF*, 45 Or App 1097, *rev den* 289 Or 337 (1980). Claim preclusion does not require actual litigation, but it does require the opportunity to litigate, whether or not used. *Drews*, 310 Or at 140.

Claim preclusion, which is the doctrine that deals with the concept of "the same aggregate of operative facts," does not apply under the facts of this case. Obviously, there was no opportunity to litigate a subsequent aggravation claim at the prior litigation. In any event, notwithstanding any distinction between claim and issue preclusion, claimant's initial premise that the "operative facts" in both litigations are the same is incorrect. The "operative facts" in the prior litigation and in the aggravation claim now before us are *not* the same. In the prior litigation, the "operative facts" were those facts relating to claimant's medically stationary status at claim closure, *i.e.*, whether any "further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). In addition, because the record established that claimant was medically stationary at the time of claim closure, the issue of extent of permanent disability was ripe. The "operative facts" regarding the extent issue were those facts relating to whether claimant was entitled to permanent disability benefits under the Director's standards. ORS 656.268(4).

On the other hand, the operative facts relating to the aggravation issue currently before us are those facts relating to whether claimant's compensable condition "actually worsened," as that term is used in ORS 656.273, since the last award of compensation. Thus, although ORS 656.273 requires comparison of claimant's condition at the time of the aggravation claim to his condition at the time of the last award of compensation, such a comparison does not render the "operative facts" the same at both points in time.

Accordingly, we withdraw our August 18, 1999 order. On reconsideration, as supplemented herein, we republish our August 18, 1999 Order on Review. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CONNIE J. BARRS, Claimant
WCB Case No. 98-04851
ORDER ON RECONSIDERATION
Edward J. Harri, Claimant Attorney
Schwabe, et al, Defense Attorneys
Kryger, et al, Attorneys

On August 25, 1999, we abated our July 30, 1999 Order on Review that reversed those portions of the Administrative Law Judge (ALJ) Kekauoha's order that: (1) set aside the self-insured employer's denial of claimant's injury claim for a T11 fracture; (2) directed it to pay interim compensation for the period of May 8, 1998 to June 5, 1998; and (3) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. We took this action to consider claimant's motion for reconsideration. Having received the employer's response and claimant's reply, we proceed with our reconsideration.

On reconsideration, claimant first contends that we erroneously rejected the causation opinions of claimant's treating doctors, Drs. Donovan and Mayhall, in favor of the assessment of Dr. Bald, who evaluated claimant at the employer's request. Claimant maintains that Dr. Bald's opinion is flawed and unpersuasive. In addition, claimant argues that we erroneously concluded that the employer had no duty to pay interim compensation. For the reasons set forth below, we adhere to our original determination.

In this compensability dispute, claimant has the burden to prove that she suffered a new fracture at T11 as a result of her February 1998 fall at work. *See* ORS 656.266. If the medical opinions supporting compensability are unpersuasive or insufficient to sustain that burden, the claim will fail regardless of the persuasiveness of the independent medical examiner's report. *See Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980) (the claimant failed to meet his burden of proving causation where only medical opinion, although unrebutted, was unexplained); *see also Dale F. Cecil*, 51 Van Natta 1010 (1999) (unrebutted medical opinion from the treating physician may be unpersuasive if unexplained, inconsistent or couched in terms of medical possibility rather than probability); *Leah A. Boyd*, 50 Van Natta 263 (1998) (even unrebutted medical opinions from treating physician may not be persuasive).

Furthermore, and contrary to claimant's contention, we did not "adopt" Dr. Bald's opinion over the opinions of Drs. Donovan and Mayhall in this case. Rather, as we explained in our prior order, we found that the opinions of Drs. Donovan and Mayhall lacked persuasive force. For example, we noted that, although Dr. Donovan opined that claimant's February 26, 1998 fall caused a T11 compression fracture, her "check-the-box" opinion lacked explanation and analysis. We also explained that, to the extent Dr. Donovan's opinion was based on Dr. Eyre's x-ray report, that report was not persuasive evidence of a new injury because it indicated only a "suspicion" of a new injury. We further determined that Dr. Donovan did not adequately address the fact that claimant did not complain of acute and severe pain localized to her lower thoracic and lumbar spine when she first sought treatment from Dr. Donovan in early March 1998.[1]

We similarly found that Dr. Mayhall's opinion was insufficient to sustain claimant's burden because it was couched in terms of possibility rather than probability.[2] *See Gormley v. SAIF*, 52 Or App 1055 (1981) (probability, not possibility, is the requisite standard of proof). We also explained that Dr. Mayhall's opinion did not address claimant's well-documented history of preexisting degenerative changes at T11-12 or respond to Dr. Burke's determination that claimant's thoracic MRI findings were consistent with a degenerative condition as opposed to a new, acute compression fracture. Finally, we noted that Dr. Mayhall's assessment could not be reconciled with Dr. Green's evaluation of claimant's December 1998 MRI scan. Because of these shortcomings, we concluded that Dr. Mayhall's opinion was unpersuasive.

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[1] Claimant first sought treatment from Dr. Donovan on March 2, 1998. She noted some tenderness of the mid-thoracic area with fairly full thoracic rotation. Claimant did not complain of acute thoracic pain to Dr. Donovan, nor did she testify that she experienced such pain after her fall. It was not until March 19, 1998, two weeks after her initial visit to Dr. Donovan (and three weeks after her fall) that claimant reported fairly localized thoracic pain feeling like a band around her back.

[2] For example, Dr. Mayhall reported that "there might be" some change in the signal at the superior end of plate T11, and that claimant "appeared to have" suffered a new injury, while acknowledging that the height of the T11 vertebra was poorly seen on the MRI scan and could not be measured. (Ex. 129).

Although we discussed Dr. Bald's report and his findings that, on his June 2, 1998 examination of claimant she had no pain complaints referable to her thoracic spine, we did not accept his opinion in favor of the opinions of Drs. Mayhall and Donovan. Instead, we simply found that, considering the "essentially irreconcilable" medical evidence in the record, claimant did not prove by a preponderance of the evidence that she suffered a new compression fracture at T11 in her February 1998 fall at work.

As noted above, claimant also argues that we came to the "wrong legal conclusion" in finding that she was not entitled to interim compensation for the period of May 8, 1998 to June 5, 1998. Notwithstanding this contention, we adhere to our determination that, because the employer denied the claim within 14 days of its receipt of medical verification of claimant's inability to work, no interim compensation became due under ORS 656.262(4)(a). Our conclusion is consistent with *Robert E. Vanwormer*, 46 Van Natta 328 (1994).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 30, 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
ALLAN Y. JIAO, Claimant
WCB Case No. CV-99001
CRIME VICTIM ORDER OF DISMISSAL (REMANDING)

Applicant requested Board review of the Department of Justice's June 22, 1999 Order on Reconsideration denying his claim for benefits under the Compensation Act for Victims of Crime. The Department denied the claim on the basis that, because "more than three years have passed since the issuance of the November 23, 1992 Determination Order denying the application," the "claim for benefits/compensation has expired[.]"

We acknowledged applicant's request and informed him that he was entitled to an in person hearing or review based on the written record. The Department then wrote to the Board that, "based on further review" of the claim, it was "reversing" its Order on Reconsideration and would be accepting the claim.

Based on the Department's correspondence, we dismiss applicant's request for Board review and remand this matter to the Department to reconsider its prior decision. In the event that applicant is dissatisfied with the Department's eventual reconsideration order, he may request Board review of that decision.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN R. HOLLANDER, Claimant
WCB Case No. TP-99006
THIRD PARTY DISTRIBUTION ORDER
Charles A. Ringo, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The self-insured employer, as paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. *See* ORS 656.593(3). Specifically, the dispute pertains to the amount of the employer's share of the settlement proceeds. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

Claimant was compensably injured in a motor vehicle accident on September 14, 1998. The claims administrator, Johnston & Culberson, accepted the claim on behalf of the employer and has provided compensation. To date, the employer has incurred actual claim costs totaling $2,406.80. These costs are composed of medical expenses.

Claimant retained legal counsel to pursue a third party lawsuit against the party responsible for the motor vehicle accident. On October 2, 1998, claimant's counsel wrote to Johnston & Culberson to advise the employer of the third party action. The letter stated that claimant would ensure that the employer's lien was protected.

On March 23, 1999, claimant's counsel wrote to the claims processor and indicated that a settlement offer had been received. Claimant stated that she would reimburse the employer's "workers' compensation lien in the amount of $2,406.80, less a one-third pro rata attorney fee for recovering the funds." On March 24, 1999, the claims processor responded that it would not approve a settlement that was not in conformance with the statute.

On April 1, 1999, claimant and the third party reached a settlement in the amount of $15,956.80.

On June 24, 1999, the employer's attorney wrote to claimant and contended that its lien was not subject to a one-third pro rate attorney fee. The employer advised that, if full payment of its total lien amount was not received within 10 days, enforcement would be sought before the Board.

Following its receipt of the employer's petition, the Board granted claimant's counsel an opportunity to respond to the employer's petition. Specifically, claimant's counsel was given 21 days to file his response, including any supporting evidence. The 21-day period having expired without claimant's counsel's response, the Board has proceeded with its review.

A distribution of the third party settlement in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit the employer to receive $2,406.80 as full reimbursement for its lien.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by Johnston & Culberson, on behalf of the employer, which has provided compensation. Inasmuch as the employer has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576.

When claimant chose to seek recovery from the third party, the provision of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to the employer's lien for its "just and proper" share. *See* ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

We are required to exercise our discretion in arriving at a "just and proper" distribution of settlement proceeds under ORS 656.593(3). *Urness v. Liberty Northwest Insurance Corporation*, 130 Or App 454, 458 (1994). Because "ad hoc" distributions are contemplated by ORS 656.593(3), it is improper for us to automatically apply the distribution scheme for third party judgments under ORS 656.593(1) when resolving disputes regarding third party settlements. *Id.* Despite the impropriety of such an automatic method, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" provided that such a determination was based on the merits of the case. *Id.*

In resolving this particular dispute, we are, therefore, mindful of the court's admonishment that we must refrain from automatically applying the third party judgment scheme when determining a "just and proper" distribution for third party settlement proceeds. *Urness v. Liberty Northwest, supra.* Thus, in reaching our determination regarding a "just and proper" distribution, we judge this case based on its own merits and not on an inapplicable statutory distribution scheme. In other words, in exercising our statutory authority under ORS 656.593(3), we do not arbitrarily adhere to the specific distribution scheme set forth in ORS 656.593(1).

Here, the employer contends that it is entitled to full reimbursement of its $2,406.80 lien in claims costs from the third-party settlement proceeds. We agree with the employer's contention.

Claimant has not contested the employer's assertion that it has incurred $2,406.80 in actual claim costs. In fact, claimant does not dispute the employer's assertion that it is entitled to full satisfaction of its statutory lien.

Pursuant to ORS 656.593(1)(c), the paying agency shall be paid and retain the balance of a third party recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8).

Where a paying agency has incurred expenditures for compensation attributable to an accepted injury claim and the claimant has not challenged the payment of those benefits, we have found it "just and proper" for a paying agency to receive reimbursement for such claim costs. *Jack S. Vogel*, 47 Van Natta 406 (1995). Inasmuch as the expenditures in this case constitute "compensation" that has previously been provided to claimant, we find it "just and proper," under the circumstances of this case, for the employer to receive full reimbursement for these expenses from claimant's third party settlement. *See* ORS 656.593(3); *Norman H. Perkins*, 47 Van Natta 488, 490 (1995). Accordingly, we conclude that the employer's "just and proper" share of the third party settlement is $2,406.80.

Rather than distributing $2,406.80 to the employer in full satisfaction of its lien, claimant's counsel has retained the amount, contending that he is entitled to a one-third "pro rata" attorney fee to be deducted from the lien. Yet, there is no statutory provision that would permit claimant's attorney to reduce the recovery of the employer's lien by an additional attorney fee. *See Dennis Youngstrom*, 47 Van Natta 1622 (1995) (The claimant's attorney was not entitled to unilaterally deduct one-fourth of the paying agency's share of a third party recovery for an additional attorney fee). *Also see Sherri L. Cody*, 44 Van Natta 2254 (1992); *Clifford S. Brush*, 44 Van Natta 954, 955 (1992). Instead, the statutory distribution scheme, which we have determined to be applicable to this case, is precise.

Specifically, pursuant to ORS 656.593(1)(a), a claimant's attorney fees in a third party recovery are initially deducted from the recovery and distributed to the attorney. Following this attorney fee distribution and litigation costs, the remaining balance of the third party recovery is distributed amongst claimant (1/3 share) and the paying agency (to the extent of its lien). Thus, the third party statutes do not provide authorization for an additional attorney fee award other than that disbursed from a third party recovery. *See Dennis Youngstrom, supra.*

In conclusion, claimant's counsel's unilateral and unauthorized action in declining to reimburse the employer until it agrees to an additional deduction of a one-third "pro rata" attorney fee is contrary to the statutory distribution scheme as set forth in ORS 656.593(1) and (3). Under such circumstances, we have previously held that the paying agency may recover its unpaid lien from claimant's attorney. *Dennis Youngstrom, supra; Steven B. Lubitz,* 40 Van Natta 450, 452 (1988).

In accordance with the reasoning discussed above, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay the employer $2,406.80 in full satisfaction of the employer's lien.

IT IS SO ORDERED.

In the Matter of the Compensation of
HELEN F. ILES, Claimant
WCB Case No. 98-09479
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) upheld the self-insured employer's denial of her right wrist injury claim; and (2) declined to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

The ALJ upheld the employer's denial, finding that claimant's injury claim was not supported by "objective findings." *See* ORS 656.005(19). Moreover, the ALJ reasoned that, because the employer's denial was proper, there were no "amounts then due" on which to base a penalty, nor was there unreasonable resistance to the payment of compensation.

On review, claimant contends that the ALJ mistakenly failed to address the evidence on medical causation in light of the employer's amendment of its denial at hearing to include a medical causation defense. Further, claimant argues that the ALJ should have assessed a penalty for an allegedly unreasonable amendment of the employer's denial to include a medical causation defense. Finally, claimant contends that her claim was supported by "objective findings." We disagree with claimant's contentions.

Like the ALJ, we, too, find it unnecessary to address medical causation. That is, we agree with the ALJ's reasoning that the injury claim was not supported by "objective findings." Therefore, even if we agreed with claimant that she established medical causation, the claim would still not be compensable. Finally, even if we assumed that the employer unreasonably denied medical causation, there would no amounts due on which to base a penalty nor unreasonable resistance to the payment of compensation in light of our finding that the claim is not compensable. *See Boehr v. Mid-Willamette Valley Food,* 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

ORDER

The ALJ's order dated March 11, 1999 is affirmed.

In the Matter of the Compensation of
CLIFFORD D. CORNETT, Claimant
WCB Case Nos. 98-05318, 98-05317, 98-05316 & 97-10236
ORDER ON RECONSIDERATION
Philip H. Garrow & Janet Breyer, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Reinisch, MacKenzie, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our August 20, 1999 Order on Review that modified the Administrative Law Judge's (ALJ's) attorney fee award of $10,260 to $4,000 under ORS 656.386(1) for the compensability issue and $1,000 under ORS 656.308(2)(d) for his counsel's services regarding the responsibility issue. Requesting *en banc* review of the attorney fee issue, claimant contends that this was more than a simple responsibility case and that we did not give sufficient consideration to the time required to litigate the compensability issue.[1] In response, the Traveler's Insurance Company requests that claimant's motion be denied. We adhere to our prior conclusion, as supplemented below.

As noted in our previous order, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee. *See Ben E. Conradson*, 51 Van Natta 851 (1999). Claimant's contentions notwithstanding, we remain persuaded that the compensability issue was of a complexity level normally faced by the Board and its Hearings Division. Accordingly, we continue of the opinion that $4,000 is a reasonable and appropriate attorney fee for claimant's counsel's services regarding the compensability issue.[2]

Accordingly, we withdraw our August 20, 1999 order. On reconsideration, as supplemented herein, we adhere to and republish our August 20, 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] Whether a case is reviewed *en banc* is a matter solely within our own discretion. *E.g., Brian W. Andrews*, 48 Van Natta 2532 (1996); *Ralph L. Witt*, 45 Van Natta 449 (1993). We note that, 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. Thus, before issuing our Order on Review, we considered whether this case warranted *en banc* review and decided it was more appropriate for review by a panel. Our conclusion is not changed by claimant's arguments. The proper standards for determining an appropriate attorney fee are well-established by administrative rule and case law. Furthermore, contrary to claimant's arguments, after reconsideration, we continue to find that we appropriately applied those standards in determining a reasonable attorney fee in this case. Consequently, while we recognize the importance of this matter to claimant, we do not consider this case to be sufficiently significant to warrant *en banc* reconsideration.

[2] Claimant argues that our award is inconsistent with that awarded in *Carrie Newton*, 50 Van Natta 1750 (1998). While comparing and contrasting other cases can be of some assistance in determining a reasonable fee, each case must ultimately be evaluated based on its own particular circumstances. *Ben Conradson*, 51 Van Natta at 852 n. 4. Here, we continue to find that $4,000 is a reasonable fee for the compensability issue, based on the factors set forth in OAR 438-015-0100(4). In so doing, we emphasize that we are not questioning the time claimant's counsel spent in preparing for and participating in the depositions and hearing. When we noted in our prior order the limited amount of questions in the depositions and hearing concerning the compensability issue, we were only recognizing the limited nature of the compensability dispute as it pertained to the "nature of the proceedings" factor in OAR 438-015-0010(4).

In the Matter of the Compensation of
HECTOR A. MARTINEZ, Claimant
WCB Case No. 98-07284
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that upheld the SAIF Corporation's denial of his C5-6 herniated disc condition. On review, the issue is compensability.

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

The ALJ found there was no evidence to corroborate a specific injury claim. The ALJ reasoned that, because the gravamen of claimant's claim was that he had sustained an injury lifting a board at work and the evidence did not support such a finding, claimant failed to prove compensability of the C5-6 herniated disc.

Citing *Donald Drake Co. v. Lundmark*, 63 Or App 261, 266 (1983), *rev den* 296 Or 350 (1984), claimant argues that the ALJ erred by upholding SAIF's denial. Claimant contends that the case law does not require a specific incident in order to have a compensable injury claim.

Claimant's argument about the *Lundmark* case misses the mark. In *Lundmark*, the court found that the claimant's back trouble "coincided precisely" with the traumatic jolting of the faulty loader. *Id.* at 266. The court noted that the fact that the claimant's pain grew progressively worse over his six-week employment did not make it "gradual in onset." *Id.* The court concluded that the claimant's back strain was the result of an injury rather than an occupational disease. *Id.*

In *Lundmark*, the claimant's back trouble began at a specific time, at the same time the problems with the loader began. Here, in contrast, the fundamental problem is identifying the onset of claimant's symptoms. The ALJ did not accept claimant's testimony that he had injured his neck lifting a specific board.

Although not statutorily required, the Board generally defers to the ALJ's credibility determination when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

On *de novo* review, we find that claimant's testimony regarding the onset of symptoms is inconsistent with the testimony of other witnesses and the history given to several physicians. Claimant, a ripsaw operator, testified that he had an injury "about two or three weeks" before he sought medical treatment on May 18, 1998. (Tr. 15). The injury occurred at approximately 1:00 p.m. (*Id.*) Claimant said he was lifting one of the boards and "throwing" it when he felt the pain. (Tr. 17). He agreed there was a specific time when he felt pain. (*Id.*) Claimant felt pain in his arm, shoulder and neck and he had a headache. (Tr. 22). He testified that he told his supervisor about the pain 15 to 20 minutes after the incident occurred and the supervisor gave him a pill. (Tr. 16, 22, 23).

Mr. Fahland, claimant's supervisor, testified that claimant told him his shoulder was hurting about two weeks before May 13, 1998. (Tr. 49). Claimant did not indicate he had a work injury or that a specific event had taken place to cause the shoulder pain. (Tr. 48, 49, 50, 54). At that time, claimant appeared to be performing his job normally and did not appear to be in pain. (Tr. 50). Similarly, Mr. Garcia, another supervisor, testified that claimant never reported a work-related injury and did not act like his shoulder was hurting. (Tr. 59, 60).

We agree with the ALJ that claimant's testimony regarding the onset of symptoms is inconsistent with the history given to several physicians. On July 2, 1998, Dr. Reichle reported that claimant "began developing pain in the left shoulder" on May 18, 1998. (Ex. 4-1). Dr. Reichle did not refer to a specific

incident and his history of onset of pain is inconsistent with claimant's testimony. Similarly, Dr. Rosenbaum reported that he had not obtained a history of a specific incident. (Ex. 10-1). Dr. Bald performed an examination with the assistance of a Spanish speaking interpreter on August 11, 1998. (Ex. 12-2). Dr. Bald reported that claimant "first noted the gradual onset of pain complaints on approximately April 30, 1998, but is unable to associate the pain with any type of specific injury or incident." (*Id.*) Dr. Bald reported that the pain began "insidiously gradually" in the left shoulder and got progressively worse over time. (*Id.*)

Dr. Puziss examined claimant on October 9, 1998 with the assistance of a Spanish interpreter. (Ex. 14-1). He reported that "in May of 1998 [claimant] began developing pain in the left shoulder." (*Id.*) Dr. Puziss said that claimant had a few days of pain and reported it on May 18, 1998. (*Id.*) Dr. Puziss' report that claimant "began developing pain" in May 1998 is inconsistent with claimant's testimony of the specific onset of pain on a particular day.

Dr. Ordonez examined claimant on January 21, 1999. (Ex. 22). Claimant testified that Dr. Ordonez speaks Spanish. (Tr. 29). Dr. Ordonez reported that although claimant's accident reportedly occurred on May 18, 1998, it "actually occurred a couple of weeks before." (Ex. 22-1). Dr. Ordonez reported that while lifting wood, claimant developed acute neck pain with left shoulder and arm radiation. (*Id.*)

Although Dr. Ordonez' history of claimant's injury is more consistent with claimant's testimony than the reports of other physicians, we note that he did not examine claimant until eight months after the apparent injury. We are not persuaded by Dr. Ordonez' history of claimant's symptoms. The preponderance of medical evidence does not refer to a specific injury at a particular time. In light of the inconsistencies with claimant's testimony and that of his coworkers, as well as the inconsistencies with the medical reports, we agree with the ALJ that the evidence does not support a finding that claimant sustained an injury while lifting a board at work.

ORDER

The ALJ's order dated April 8, 1999, as reconsidered April 13, 1999, is affirmed.

September 14, 1999 Cite as 51 Van Natta 1507 (1999)

In the Matter of the Compensation of
LAURA M. CLARK, Claimant
WCB Case No. 98-09502
ORDER DENYING RECONSIDERATION
Stebbins & Coffey, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our August 17, 1999 Order on Review that affirmed the Administrative Law Judge's order upholding the SAIF Corporation's denial of claimant's aggravation claim for a right knee condition. In asking for abatement and reconsideration, claimant continues to argue that her treating physician provided the most persuasive opinion and, thus, she carried her burden of proof.

We find that our order adequately analyzes the medical opinion evidence and explains our conclusion that claimant did not prove a compensable aggravation. Accordingly, we deny claimant's motion and adhere to our August 17, 1999 order. The parties' rights of appeal shall continue to run from the date of that order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUTH D. MELLEN, Claimant
WCB Case No. 98-03562
ORDER ON REVIEW
Jensen, Elmore & Stupasky, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for a right trigger thumb condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. On page 2, we replace the first paragraph with the following:

> "Claimant was off work for about ten days after the dog bite injury and went back to work in November 1996. (Tr. 30-31). She returned to light duty work outside of the press room. (Tr. 31-32). Claimant did not perform normal duties in the press room until she was asked to perform a rush job around February 14, 1997. (Tr. 30-32). She had trouble using the 'T-wrench' at work at that time and thereafter. (Tr. 48-49). Claimant worked in the press room occasionally between February 1997 and July 1, 1997, approximately 20 times. (Tr. 32). She said her right thumb started "clicking" in June 1997. (Tr. 47). Claimant was not back in the press room full time until July 1, 1999. (Tr. 32)."

In the third paragraph on page 2, we delete the last sentence.

On page 3, we change the fourth paragraph to read:

> "On July 21, 1998, Dr. Schroeder reported that claimant's work exposure 'may have aggravated the trigger thumb' condition, but he said that 'the exact cause is not known and cannot be necessarily attributed to her work.' (Ex. 13). Although Dr. Ganter agreed that claimant's work activities were the major contributing cause of her current need for treatment and disability (Ex. 14), Dr. Schroeder neither agreed nor disagreed with Dr. Ganter's conclusion. (Ex. 15)."

On page 4, we replace the first and second paragraphs with the following:

> "Both Drs. Schroeder and Ganter were deposed by the parties. (Exs. 17, 18)."

We do not adopt the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was employed as an offset printing press operator and bindery worker from May 1985 through August 1997. She contends that her work activities for the employer were the major contributing cause of her right trigger thumb condition. The causation issue is complicated by a dog bite injury to claimant's right hand on October 29, 1996, in which she sustained a fractured second metacarpal. (Exs. 10, 17-5).

The ALJ relied on the opinions of Drs. Ganter and Schroeder to establish compensability of the right trigger thumb condition. On review, the insurer argues that the ALJ's conclusion that the right trigger thumb condition is compensable is inconsistent with claimant's testimony and rests upon a misinterpretation of the expert medical evidence.

Because of the number of potential causes of claimant's trigger thumb condition, the causation issue presents a complex medical question requiring expert 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 well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

We first address the standard of proof for this occupational disease claim. Dr. Ganter did not believe claimant had a preexisting condition related to her right thumb. (Ex. 18-40). Dr. Schroeder was not aware of any preexisting condition in claimant's right hand or thumb before the October 1996 dog bite injury. (Ex. 10-2). Based on the medical reports, claimant did not have a preexisting disease or condition related to the right trigger thumb condition. Consequently, we conclude that ORS 656.802(2)(a) applies and claimant must prove that her employment conditions were the major contributing cause of the right trigger thumb condition.

Claimant relies on the opinion of her treating physician, Dr. Ganter, to establish compensability. She also contends that Dr. Schroeder's deposition testimony supports compensability. We generally give greater weight to the opinion of a claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the following reasons, we find that the opinions of Drs. Ganter and Schroeder are not sufficient to establish compensability of the right trigger thumb condition.

Dr. Ganter first treated claimant on March 31, 1997, after she had sustained a dog bite injury to her left hand.[1] (Exs. 1A-1, 18-5). Dr. Ganter's chart notes did not refer to any right thumb problems until August 29, 1997, when he reported that claimant had been placed back in her previous job as a printing press operator a few weeks ago and "again developed hand symptoms, in particular, thumb dysfunction, swelling, and snapping of the tendon." (Ex. 1A-3). He diagnosed a trigger thumb of the right thumb. Dr. Ganter believed that claimant's work was the major contributing cause of her disability and need for treatment of the right trigger thumb. (Ex. 18-28, -31, -42, -43).

We are not persuaded by Dr. Ganter's opinion because he did not have an accurate understanding of claimant's treatment for the October 1996 dog bite injury, her modified work after that time or her work activities in general. At a deposition, Dr. Ganter said he was not familiar with the details of claimant's October 1996 dog bite injury to the right hand and was not aware if she had worn a splint or cast following that injury. (Ex. 18-16, -18). He testified that when he treated claimant in May 1997, he was not aware that she was performing light or modified work at that time. (Ex. 18-10). When Dr. Ganter was asked about claimant's modified work after the October 1996 dog bite injury, he said he was "not aware that she was not involved in an activity that required her to repetitively use and strain her right hand." (Ex. 18-19). He testified he did not understand the "ergonometrics" of claimant's work and he acknowledged he was not a "hand specialist." (Ex. 18-20, -31). When Dr. Ganter was asked about Dr. Jewell's opinion on causation (that focused on the details of her work activities), Dr. Ganter responded:

> "I can't really comment on his description of her work. From my nonexpert understanding of the mechanics of the hands, I don't think you can separate the thumb function from a complex movement that you have to perform at a machine." (Ex. 18-44, -45).

In light of Dr. Ganter's testimony, we find that he did not have an accurate understanding of claimant's modified work or her work activities in general. Consequently, Dr. Ganter's opinion is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Furthermore, we are not persuaded by Dr. Ganter's opinion on causation because he did not evaluate or consider other possible causes of her condition. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Claimant testified that she had a hobby of making kites. (Tr. 44, 45). After the October 1996 dog bite injury, claimant tried using scissors for the first time in June 1997 and found she had problems using them. (Tr. 44, 45, 47). In a deposition, Dr. Ganter agreed that use of scissors could cause a trigger thumb, but he did not have a history that claimant had used scissors. (Ex. 18-53). In addition, he had not explored whether claimant might be suffering from residual symptoms from her prior carpal tunnel syndrome. (Ex. 18-37). In sum, we conclude Dr. Ganter's opinion is not sufficient to establish compensability of the right trigger thumb condition.

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[1] This was a separate injury from the October 1996 dog bite injury to claimant's right hand.

Similarly, we find that Dr. Schroeder's opinion does not support compensability. He first examined claimant on November 11, 1996 after the October 1996 dog bite injury. (Ex. 17-4). Claimant had a laceration over the back of her hand and a fractured second metacarpal. (Exs. 10, 17-5). She was placed in a splint and had occupational therapy. (Ex. 10). On June 9, 1998, Dr. Schroeder said that the "exact cause for the trigger thumb is not known, although these are commonly seen and are not necessarily related to work activities. (Ex. 10-2, 03). Likewise, he reported on July 21, 1998 that claimant's work exposure "may have aggravated the trigger thumb but the exact cause is not known and cannot be necessarily attributed to her work." (Ex. 13).

In a deposition, Dr. Schroeder said that claimant's use of scissors regarding her hobby of making kites could be the kind of repetitive activity that could cause a trigger thumb. (Ex. 17-8, -9). He also said that it was possible that claimant's right hand splint may have put her hand in such a position that she was using her thumb in an unusual manner. (Ex. 17-9). Dr. Schroeder said he would need to know more about claimant's work activities to determine if they were the major contributing cause of her condition. (Ex. 17-13, -14). He did not know whether her work was the major contributing cause of her condition. (Ex. 17-16). Later in the deposition, however, Dr. Schroeder agreed with claimant's attorney that if he assumed that claimant had more repetitive type activities at work than at home, he could "assume" that work was the major contibuting cause. (Ex. 17-17). On the other hand, Dr. Schroeder agreed that if claimant's trigger thumb developed in June and she was not working in the press room until July, it was unlikely that the press room activities caused her trigger thumb. (Ex. 17-19). If claimant was only working in the press room about an hour a day, Dr. Schroeder said that would not be enough to start a trigger thumb. (Ex. 17-21). He explained that by repetitive use, he meant "eight hours a day, in which she was really using her hands a lot." (*Id.*) When read as a whole, we conclude that Dr. Schroeder's causation opinion is not sufficient to establish that claimant's work activities were the major contributing cause of her right trigger thumb condition.

Finally, Dr. Jewell's opinion on causation does not support compensability of claimant's right trigger thumb. Dr. Jewell did not believe there was evidence of a repetitive motion disorder or an occupational overuse of the hand. (Ex. 7-4). He explained:

> "The claimant utilizes a variety of cylinder-grip activities with respect to the turning of handles and wheels on the press for the micro-adjustments. She does not utilize any type of scissor or tool which would place direct pressure on the thumb A-1 pulley specifically. Considering all factors involved here, I believe that the cause of the stenosing tenosynovitis involving the right thumb A-1 pulley would not relate to the claimant's work activities. There is no history of occupational trauma, specific implement use, or ergonomics that would place strain or pressure on the right thumb at this level." (*Id.*)

Dr. Jewell felt that she appeared to have residuals attributable to the dog bite injury. (*Id.*)

In sum, we conclude that the medical evidence is insufficient to establish compensability of claimant's right trigger thumb condition. Consequently, we reverse that portion of the ALJ's order.

ORDER

The ALJ's order dated April 6, 1999 is reversed in part. That portion of the ALJ's order that set aside the insurer's denial of claimant's right trigger thumb condition is reversed. The insurer's denial of that condition is reinstated and upheld. The ALJ's attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JOANN K. RUSSUM, Claimant
WCB Case No. 97-09563
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Claimant requests reconsideration of our August 17, 1999 order that reversed an Administrative Law Judge's (ALJ's) order that awarded permanent total disability and reinstated an Order on Reconsideration's award of 21 percent unscheduled permanent disability for a low back condition. Contending that claimant is permanently and totally disabled and would be willing to seek regular, gainful employment, claimant asks that the ALJ's order be affirmed.

As we discussed in our prior order, even if claimant can establish that a work search would be futile, she must nevertheless prove that, but for the compensable injury, she is willing to work. *SAIF v. Stephen*, 308 Or 41 (1989). In other words, a finding of futility alone is not sufficient to support an award of permanent and total disability benefits, as a finding that claimant is willing to work is a prerequisite to entitlement to such benefits. *See* ORS 656.206(3); *Champion International v. Sinclair*, 106 Or App 423 (1991).

Therefore, even if claimant establishes that a work search would be futile because of her disability alone or the combination of her disability, age, lack of transferable skills and lack of available jobs, she must nevertheless prove that she is or would be willing to seek regular gainful employment. *Stephen*, 308 Or at 48; *Sinclair v. Champion International*, 117 Or App 515 (1992).

Thus, even if we were to rely on Dr. Long's, Dr. Hill's and Dr. Burke's medical opinions, the findings of the Social Security judge, and vocational counselor Mr. Ross's determination that it would be futile for claimant to seek work, as advocated by claimant, we would nevertheless conclude that the evidence fails to establish that claimant is or would be willing to work "but for" her compensable conditions.[1]

Accordingly, as supplemented herein, we adhere to our August 17, 1999 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] We contrast the circumstances of this case, in which there is no evidence that claimant has made any efforts to seek work or is willing to work, with those in *Robert D. Price*, 45 Van Natta 1448 (1993), cited by claimant. In *Price*, we agreed with the ALJ's finding that claimant was presently unable to obtain and perform any work at a gainful and suitable occupation. We further found that the claimant's minimal efforts to seek work showed that the claimant was willing to seek work and had made reasonable efforts to do so. Because the claimant in *Price* had demonstrated that he was willing to seek work, he therefore established that he was permanently and totally disabled.

In the Matter of the Compensation of
MARK E. LANDON, Claimant
WCB Case No. 98-02810
THIRD ORDER OF DISMISSAL
Bryant, Emerson, et al, Claimant Attorneys
Stoel, Rives LLP, Defense Attorneys

On September 7, 1999, we abated our August 11, 1999 Second Order of Dismissal that continued to dismiss claimant's request for hearing on the ground that it was not timely filed. We took this action to consider claimant's second motion for reconsideration. Having received the self-insured employer's response opposing the motion, we proceed with our reconsideration.

In dismissing claimant's request for review, we found that it was not timely filed because the final day to perfect a timely appeal was Monday, June 14, 1999 and we received the request on June 21, 1999. Accompanying claimant's first motion for reconsideration was an affidavit completed by his attorney explaining that counsel personally prepared the request and placed the correspondence "in the out going mail basket to be postmarked at a time that I was sure was before our staff person takes the mail over to the" post office.

Our Second Order of Dismissal continued to conclude that claimant did not overcome the presumption that the request was not timely filed because it was not mailed by registered or certified mail and we received it after the expiration of the 30-day appeal period. OAR 438-005-0046(1)(a). In particular, we found the information in the affidavit insufficient to show that the request for review was "filed," or mailed, on June 14, 1999 because claimant's attorney stated only that he put the request in his office's "out going mail basket," which we found did not show that the thing was *mailed* on that date. Furthermore, based on this conclusion, we found it unnecessary to address the effect, if any, of the fact that the envelope containing the request for review was postmarked June 16, 1999.

Claimant's second request for reconsideration is accompanied by two more affidavits. In the first affidavit, claimant's counsel states that, on June 14, 1999, after he put the request for hearing in the "mail basket," he saw the office receptionist "running all remaining unmetered mail through the postage meter including the mail in this case" and then "saw her gather all the mail together including the mail in this case and leave for the post office."

The second affidavit is from the office receptionist and states that part of her job responsibilities is to postmark outgoing mail and then take the metered mail to the post office. The affidavit further provides that, on June 14, 1999, "[a]ll mail that was in the outgoing mail bin * * * including the mail placed in the bin by [claimant's attorney] in the above entitled matter, was taken by me to the post office that day and placed in the mail before 5:30 which I believe is the last time that metered mail will be accepted."

We again note that, because the request for review was not mailed by registered or certified mail and we received it after the expiration of the 30-day period, we presume that the request was not timely filed. We continue to find that claimant did not overcome this presumption. In particular, the affidavits do not address or explain why the request for review was postmarked June 16, 1999 if it was metered and mailed on June 14, 1999.

Counsel's affidavit accompanying his first motion for reconsideration indicated that his office uses a "Pitney Bowes" mail meter and he "asked the office personnel if they could remember anything unusual about the procedures used on the date in question" and none of the staff "knew anything about this issue." Although the affidavit also discussed the possibility that the mail meter was not dated correctly on June 14, 1999, we understand the affidavit as indicating that neither counsel nor his staff had direct knowledge that the mail meter was "wrongly" dated on June 14, 1999.

Because the envelope was dated June 16, 1999, and, according to counsel, his own office metered and postmarked the envelope containing the request for review, we find it to be strong evidence of the date of mailing. That is, the information contained in the affidavits is not sufficient to overcome the presumption when there also is evidence that the request for review was not mailed until June 16, 1999.

Accordingly, we withdraw our July 12, 1999 and August 11, 1999 orders. On reconsideration, as supplemented herein, we adhere to and republish our July 12, 1999 and August 11, 1999 orders that dismissed claimant's request for Board review as untimely filed. 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
TERRIE A. McLARRIN, Claimant
WCB Case No. 97-09427
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's denials of claimant's low back conditions at L2-3 and L5-S1. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

We substitute the following for the last sentence in the fifth paragraph on page 2: "There is no evidence in the record of medical treatment between September 1995 and May 5, 1997."

We substitute the following for the sixth paragraph on page 2 and the paragraph on page 3:

On April 7, 1997, claimant began working for the employer as a box assembler on the second shift. On May 5, 1997, at about 5:15 pm, she fell over some empty boxes, landing on her right knee and left hand. (Ex. 124). She sought treatment at an emergency room (ER) about three hours later, complaining of low back pain with radiation down the back of the right leg and into the left hip. (Ex. 125). She was diagnosed with low back pain with right sciatica and a contusion of the left hand. (Exs. 125, 128). The employer accepted a low back strain and left hand contusion.

Claimant was off work until May 8, 1997, when Dr. Larsen released MET to light duty with limited lifting, sitting, bending and squatting. (Ex. 128). Claimant returned to her work at the employer and to her other full-time employment, where she sat and soldered electronics equipment.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's L2-3 and L5-S1 low back conditions were not compensably related to her May 5, 1997 injury. On review, claimant argues that Dr. Misko's opinion is the most persuasive and should be relied on to establish the compensability of those conditions. We affirm the ALJ's ultimate conclusion, but we offer the following rationale.

We begin with a brief summary of the facts for the convenience of the reader. Claimant, age 55, suffered a compensable low back injury at a different employer in 1983 that resulted in a bilateral L4-5 laminectomy in 1983 and a repeat laminectomy at the same level in 1987. (Exs. 27, 70, 75). As early as April 1984, claimant was diagnosed with degenerative disc disease at L5-S1. (Ex. 41-2).[1]

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[1] Claimant was awarded a total of 55 percent unscheduled permanent disability for the L4-5 injury. (Exs. 47, 54, 57, 93).

In September 1988, claimant experienced a motor vehicle accident that exacerbated her chronic low back and right leg pain. (Ex. 98). Additional exacerbations occurred in December 1989 after a long drive, and in April 1990, April 1991, June 1992, December 1992, and March 1993 after slip and falls. (Exs. 102, 110, 115, 119, 120, 121-2). X-rays revealed no significant changes in her low back between April 1991 and March 1993. (Exs. 116, 118, 122).

In April 1994, claimant complained of back spasms and, subsequently, pair into the legs, worse on the right, which failed to improve. (Ex. 123-3, -4, -8, -9). She reported that she had seen a back specialist in November 1994, and in March 1995 she had a MVA which caused further exacerbation of her back and right leg pain. (Ex. 123-10, -11). On September 28, 1995, her treating physician recommended that she receive further back treatment from Dr. Bergquist. (Ex. 123-15). However, there is no record of any further back treatment until May 5, 1997.

On May 5, 1997, claimant tripped and fell at the employer, landing on her left hand and right knee. She sought emergency room treatment a few hours later, complaining of low back pain with radiation down the back of the right leg and into the left hip. (Exs. 124, 125). She was diagnosed with low back pain with right sciatica and a left hand contusion. (Exs. 125, 128). The employer accepted a low back strain and left hand contusion.

Claimant was off work for two more days. On May 8, 1997, Dr. Larsen released her to light duty with limited lifting, sitting, bending and squatting. (Ex. 128). She returned to her work at the employer and to her other full-time employment, where she sat and soldered electronics equipment. She continued to complain of low back pain, and, on June 27, 1997, Dr. Coletti, orthopedist, diagnosed a disc at L2-3, which he regarded as a new injury unrelated to her prior surgeries. (Exs. 137, 140, 143, 151).

Radiographic studies confirmed a focal disc protrusion and anterolateral extradural filling to the right at L2-3; severe disc narrowing and stenosis on the left at L4-5 with possible left nerve root entrapment; and a minimal central disc bulge at L5-Sl. (Exs. 152, 153). After reviewing these studies, Coletti was reluctant to recommend surgery for the L2-3 disc prolapse without a frank herniation and requested an independent medical evaluation regarding possible surgery at the L2-3 level. (Exs. 156, 157).

After receiving the results of the evaluation by Drs. Reimer and Peterson, in which they opined that the L2-3 bulge was not symptomatic or related to "an acute traumatic event," Coletti interpreted an October 16, 1997 bone scan to confirm that post-surgical degeneration of the L4-5 disc was the primary problem. (Ex. 163). Coletti concluded that claimant might therefore be a candidate for a possible fusion at L4-5 and referred her to Dr. Misko, neurosurgeon. (Ex. 165).

On December 7, 1997, claimant sought emergency room treatment for low back and bilateral leg pain, worse on the right especially with flexion. She reported that her condition had worsened over the prior month. (Ex. 171).

On January 29, 1998, Dr. Coletti opined that the May 5, 1997 strain had combined with claimant's preexisting low back condition, that the strain was medically stationary without permanent impairment, and that the preexisting condition was the major contributin cause of claimant's current condition. A February 26, 1998 Determination Order closed the claim and awarded no permanent disability. (Ex. 176).

On April 8, 1998, Dr. Misko diagnosed a disc protrusion at L2-3, a collapsed disc space and foraminal stenosis at L4-5, and marked instability at L5-S1, with disc protrusion and bilateral foraminal stenosis. (Ex. 177B). He performed a laminectomy and discectomy at L2-3, central and right; bilateral foraminotomies at L4-5; and bilateral foraminotomies, discectomies, Ray cage fusion, laminectomies with cauda equina and nerve root decompression at L5-S1.

Claimant was examined for the employer by Dr. Rosenbaum on November 30, 1998. Dr. Reimer reviewed the motion x-rays and Dr. Misko's and Dr. Rosenbaum's reports.

Claimant has the burden to prove that her May 1997 injury is the major contributing cause of her L2-3 and L5-S1 conditions. ORS 656.005(7)(a)(B). Given the contrary causation opinions of the medical experts and claimant's preexisting history of ongoing symptoms and treatment, we conclude that the causation issue in this case involves complex medical issues 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). Special deference is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find persuasive reasons not to defer to the opinion of Dr. Misko. In so doing, we do not adopt the ALJ's rationale that the L2-3 disc was not herniated and did not impinge the nerve root, or that there was no record evidence that the L2-3 disc was not in existence prior to the May 1997 injury.[2] We also do not adopt Dr. Reimer's or Dr. Rosenbaum's opinion that claimant did not have instability at L5-S1.

However, Dr. Misko's opinion regarding the L2-3 herniated disc was based solely on the finding of a "new" herniated disc at L2-3 after the May 1997 injury. (Ex. 180). Dr. Misko did not establish that claimant's injury was the major contributing cause of her L2-3 condition, rather than merely the precipitating cause, nor did he discuss the contribution of claimant's preexisting condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (1995). Furthermore, as noted by the ALJ, Dr. Misko inaccurately assumed that claimant's May 1997 injury at L5-S1 was so severe that she would have been unable to work prior to the injury, implying that she was unable to work because of the L5-S1 instability afterward. As noted by the ALJ, claimant lost only two days of work, was able to continue working at two jobs until she quit her job at the employer in July 1997, and continued to work at the soldering job until the time of surgery. Finally, as further noted by the ALJ, Misko did not discuss the history taken in the ER in December 1997 that for the past month claimant had experienced increased low back and bilateral leg pain that was worse on the right with flexion.

For these reasons, we conclude that the record does not satisfy claimant's burden of proving that her May 1997 injury was the major contributing cause of the L2-3 herniated disc or the L5-S1 instability. Therefore, we affirm the ALJ's ultimate decision that claimant has not established that her L2-3 and L5-S1 conditions are compensable conditions.

ORDER

The ALJ's order dated February 8, 1999 is affirmed.

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[2] The record reveals the opposite. Prior to claimant's May 1997 on-the-job fall, she had numerous studies of her lumbar spine, none of which showed any defect at L2-3. (Exhibits 11, 32, 33, 62, 70, 95, 106, 112, 116, 118, 122).

In the Matter of the Compensation of
LINDA R. MIDDAGH, Claimant
WCB Case No. 97-05847
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Steven Maher, Defense Attorney

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 partial denial of claimant's claim for a right posterior tibial tendon injury; and (2) awarded an assessed attorney fee. On review, the issues are compensability and attorney fees.

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

On review, the employer contends that the ALJ erred by not relying on the opinions of Drs. Tesar, Williams and Scheinberg, rather than the opinion of claimant's treating podiatrist (Dr. DeMuth), in determining compensability of the tibial tendon injury. We disagree. Dr. Tesar saw claimant on one occasion and acknowledged that she may have had an injury in the area of the tibial tendon although by the time of his examination, Dr. Tesar did not feel that claimant's continued complaints would be due in major part to the compensable accident.

In light of the fact that Dr. Tesar examined claimant on only one occasion, and because his specialty is orthopedic surgery and the exam he performed addressed numerous areas of injury such as the shoulder, we do not find his opinion to be more persuasive than that of Dr. DeMuth. Similarly, Drs. Williams and Scheinberg saw claimant on only one occasion and discussed numerous conditions but did not specifically address the tibial tendon condition. Accordingly, we do not agree with the employer's argument that Dr. DeMuth's opinion was less persuasive than the opinions of the aforementioned doctors.

The employer also contends that Dr. DeMuth's opinion is deficient because it is primarily based on a "but for" analysis. We agree with the ALJ that Dr. DeMuth considered other factors in addition to the fact that claimant did not previously experience right foot symptoms. Specifically, Dr. DeMuth reviewed claimant's bone scans, including one taken before the injury. Dr. DeMuth also considered the mechanism of the injury, claimant's objective findings following the injury, claimant's weight and predisposition (flat feet), and the fact that claimant did not have problems in her uninjured foot. (Ex. 92-13.) Under the circumstances, we agree with the ALJ that Dr. DeMuth's opinion supports compensability of the posterior tibial tendon condition.

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

ORDER

The ALJ's order dated March 31, 1999 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,400, to be paid by the employer.

In the Matter of the Compensation of
CYNTHIA R. DERONDEN-POS, Claimant
WCB Case No. 98-06269
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Phillips Polich

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

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the following sentence: "After the injury incident, claimant has continued to have pain that waxes and wanes."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her thoracic, or mid-back, on January 21, 1998. In April, claimant was diagnosed with a herniated disc at T6-7. The ALJ found that the more persuasive medical evidence showed that the January 1998 injury was the major contributing cause of the herniated disc and, thus, concluded that claimant proved compensability. The insurer challenges this conclusion, asserting that claimant did not carry her burden of proof.

Following the January injury, claimant treated with Dr. Shulsinger. On February 11, 1998, Dr. Shulsinger recorded that claimant's "back is actually doing well and it is pretty much back to normal now[.]" (Ex. 5). Dr. Shulsinger further noted that claimant's "back shows completely normal range of motion and no further muscular tightness" and diagnosed "back strain, resolved." (*Id.*)

On March 4, 1998, Dr. Shulsinger again recorded that claimant "is actually doing better and her back pain has now completely resolved." (Ex. 1). Dr. Shulsinger found "normal range of motion" with no "localizing tenderness" and diagnosed "thoracic strain, resolved." (*Id.*)

On April 16, 1998, claimant saw Dr. Shulsinger after experiencing symptoms of "extreme tenderness" and "burning" in her buttocks and thighs for several days. (Ex. 7-1). Claimant also felt "some mild thoracic spine burning for about 1 day and this has resolved." (*Id.*) Dr. Shulsinger diagnosed "transient lumbar radiculopathy" and thought that the incident was not related to her industrial injury. (*Id.*)

On April 29, 1998, claimant again saw Dr. Shulsinger because she was having "a lot of pain in her left lateral T-spine area and a lot of burning and pain in both legs." (*Id.* at 2). Dr. Shulsinger diagnosed "probable thoracic spine strain." (*Id.*) After an MRI showed a "right paracentral disk protrusion at the T-6 to T-7 level," Dr. Shulsinger referred claimant to a neurologist. (Ex. 10).

Dr. Bert, orthopedic surgeon, saw claimant to evaluate her back condition. Dr. Bert recorded a history that, following the January 1998 injury, claimant "developed pain and burning in her upper back which has persisted[.]" (Ex. 16).

Claimant then saw examining physicians Dr. Fuller and Dr. Radecki, who reported that, following the January injury, claimant "confirms that she did make an excellent recovery having none but occasional minor discomfort" but in mid-April suffered from the flu and had persisting back symptoms. (Ex. 17-2, 17-3). Based on this history, the panel found that claimant "appeared to have a thoracic muscle strain in January 1998 with rapid resolution of symptoms by 2/11/98[.]" (*Id.* at 5).

The panel further reported that "the finding of the right-sided disc herniation at T6-7 is incidental and not caused by her work incident" because claimant's symptoms in January and February were consistent with a muscle strain that "improved rapidly" and claimant "would have had acute

persistent pain at T6-7 on the right side of her mid-thoracic spine with right-sided intercostal nerve radiation and hypesthesia" when the "record is clear that she did not have this type of presentation." (*Id.*) Finally, the panel found it "hard to attribute the current need for treatment" to the herniated disc based on Dr. Shulsinger's findings on April 29 of *left-sided* symptoms that "suddenly switched" to the right side when Dr. Shulsinger saw claimant on May 6. (*Id.* at 7).

Dr. Young, radiologist, then performed a record review. He thought that the MRI showed "degenerative joint disease involving the T6 and T7 vertebral body levels" and that the "degree of degenerative disc dehydration noted at the T6-7 disc suggests a period considerably longer than two years." (Ex. 18-2). Dr. Young further explained that "thoracic disc protrusion/herniations are very rare" and "they are generally secondary to degenerative disc disease or catastrophic injury." (*Id.* at 3). According to Dr. Young, claimant's "clinical course is more consistent with a thoracic sprain rather than a disc herniation on the basis of complete resolution of symptoms within three weeks following the injury and subsequent exacerbation (waxing and waning) of symptoms while remaining neurologically intact." (*Id.*) Finally, Dr. Young reported that claimant's injury combined with her preexisting degenerative condition and that the major contributing cause of her current need for treatment was the preexisting condition. (*Id.* at 4).

Dr. Bert reported that the January 1998 injury was the major cause of claimant's need for treatment and disability "based upon the history of her injury and the nature of the injury." (Ex. 20).

Dr. Shulsinger reported that he found no "evidence of pre-existing T-spine disease" and that the major contributing cause of the disc herniation was the January injury. (Ex. 24-1). Dr. Shulsinger also explained that symptoms from a disc herniation can "wax and wane." (*Id.* at 2).

In evaluating the persuasiveness of medical evidence, we generally defer to the opinion of the treating physician, absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to either Dr. Shulsinger's or Dr. Bert's opinions.

First, it appears that, based on the record, Dr. Bert had seen claimant only one time before rendering his opinion. Based on this limited contact, we find that Dr. Bert is in no better position than the examining panel of Drs. Fuller and Radecki, who also saw claimant one time. Furthermore, Dr. Bert essentially provides no reasoning or explanation for his conclusion. Specifically, Dr. Bert supports his opinion only with the reasoning that it is "based upon the history of her injury and the nature of the injury." Dr. Bert does not explain in particular how the history and nature of the injury shows that it was the major contributing cause of the disc herniation.

Additionally, Dr. Bert relies on a history that claimant's symptoms persisted after the January 1998 injury, which we find indicates a lack of understanding that claimant's strain condition resolved shortly after the incident, followed by an exacerbation and worsening of symptoms.[1] Thus, Dr. Bert relied on an inaccurate history.

Dr. Shulsinger's opinion has similar deficiencies. The examining panel and Dr. Young in part relied on Dr. Shulsinger's chartnotes that claimant's strain resolved by mid-February in finding that the January 1998 incident caused only a thoracic strain and not the disc herniation. In responding to these reports, Dr. Shulsinger explains only that symptoms from a disc herniation can "wax and wane." We find such reasoning insufficient to explain why symptoms consistent with a disc herniation would not appear until months after the compensable injury, preceded by a resolution of her strain injury.

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[1] On review, claimant relies on her testimony that she "tried to be tough" to explain why Dr. Shulsinger indicated that her condition had resolved. At hearing, claimant testified that her symptoms actually "waxed and waned" without resolving after the accident.

We find Dr. Shulsinger's chartnotes to be more reliable evidence concerning claimant's condition in February and March. Claimant testified in March 1999, over a year after the accident, whereas Dr. Shulsinger's notes were contemporaneous with his examinations. Furthermore, Dr. Shulsinger did not only provide claimant's reporting of her condition but also relied on his examination findings in diagnosing that her strain had resolved. Consequently, we find that claimant's strain did resolve in February and March and then, in mid to late-April, her condition exacerbated.

Like Dr. Bert, Dr. Shulsinger also does not explain how claimant's injury caused the disc herniation. Thus, we also find it to be conclusory. Finally, Dr. Shulsinger simply denies that claimant has a preexisting condition without responding to Dr. Young's point that the disc herniation appeared to be at least two years old.

In sum, we find the medical opinion, at best, to be in equipoise. Because we are not more persuaded by the opinions of Dr. Shulsinger and Dr. Bert, we conclude that claimant did not carry her burden of proving compensability.

ORDER

The ALJ's order dated May 6, 1999 is reversed. The insurer's denial of claimant's thoracic disc herniation condition is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability. Instead, I would affirm the ALJ's order concluding that claimant carried her burden of proof that her current thoracic herniation condition is compensable.

In particular, I agree with the ALJ that Dr. Shulsinger and Dr. Bert provided sufficiently persuasive opinions proving that the January 1998 injury was the major contributing cause of the herniation. Dr. Shulsinger began treating claimant shortly after the January 1998 event and has had extensive contact with claimant. Although Dr. Shulsinger does not explicitly address whether claimant's condition resolved before April 1998, he stated that symptoms from a disc herniation can come and go. He further explained that in his 22 years of medical experience, "waxing and waning" was classic with disc herniation. I find that such evidence shows that Dr. Shulsinger did not consider claimant's condition as having resolved from her work injury of January 1998.

For this reason, I especially disagree with the majority's rejection of claimant's testimony that her symptoms "waxed and waned" following the January 1998 injury. The majority does so based on Dr. Shulsinger's chartnotes from February and March. As explained above, however, it is apparent that Dr. Shulsinger himself believed that claimant's condition did not resolve after the January 1998 injury. Because Dr. Shulsinger's opinion of claimant's condition is consistent with her testimony, and I find Dr. Shulsinger's present opinion more persuasive than the majority's interpretation of his chartnotes, I find no reason for rejecting claimant's testimony that her condition did not resolve.

In sum, as they actually treated claimant and their opinions were based on an accurate history and were well-reasoned, I find no reason not to defer to the opinions of Dr. Shulsinger and Dr. Bert. Both explained how, when claimant lifted and pushed an 80 to 90 pound child into a standing position, she sustained a thoracic spine herniation. Because the majority comes to a different conclusion, I dissent.

In the Matter of the Compensation of
JOY E. DIEDRICH, Claimant
Own Motion No. 99-0305M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights expired on April 14, 1993. The insurer agreed that claimant's current cervical condition was causally related to her accepted condition and that it is responsible for claimant's current condition. However, the insurer opposed reopening on the grounds that claimant was not in the work force at the time of the current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). Here, claimant must prove that she was in the work force on May 14, 1999, when she underwent surgery for her current cervical condition. A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular, gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In response to the insurer's work force contentions, claimant asserts that, although willing to work, she was disabled due to two unrelated work injuries. Claimant notes that she was disabled due to an injury to her right thumb from February 14, 1999 through April 6, 1999. From April 21, 1999 through June 8, 1999, she was collecting temporary disability compensation for a work-related injury to her right long finger.

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). In other words, the relevant time period for which claimant must establish that she was in the work force is the time prior to her May 14, 1999 surgery, when her condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Kepford*, 100 Or App at 414; *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, on May 14, 1999, claimant underwent a posterior cervical laminotomy and discectomy. At that time, claimant was receiving temporary disability under an accepted right long finger claim with another carrier. Since claimant was receiving temporary disability compensation under another workers' compensation claim at the time of her disability in this claim, she is considered to be in the work force. *See Michael C. Johnstone*, 48 Van Natta 761 (1996); *William L. Halbrook*, 46 Van Natta 79 (1994).

Therefore, we conclude that, at the time of claimant's current disability, she did not voluntarily remove herself from the work force, but, rather, was disabled due to another compensable injury. Consequently, we find that claimant has established that she was in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's 1988 claim to provide temporary disability compensation beginning May 14, 1999, the date she was hospitalized for the proposed surgery.[2] When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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

[2] In making this authorization, we note that claimant sustained a separate work injury for which she received time loss benefits. Claimant is not entitled to receive double the statutory sum for the same period of time loss because she has at least two separate disabling injuries. *Fischer v. SAIF*, 76 Or App 656, 661 (1985); *Petshow v. Portland Bottling Co.*, 62 Or App 614 (1983), *rev den* 296 Or 350 (1984). Therefore, if claimant received time loss for her right long finger injury claim for a period coinciding with her temporary disability award under this claim, the insurer is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. *See* OAR 436-060-0020(8); *Leroy R. Fowler*, 41 Van Natta 1468 (1989).

In the Matter of the Compensation of
CHARLES R. DREW, Claimant
Own Motion No. 98-0491M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's April 21, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from *"September 16, 1986"* through *"October 30, 1986."* The insurer declared claimant medically stationary as of April 16, 1999.

In his request for review, claimant requests review of the closure and notes that "I have spoken to Dr. Matteri['s] office, and have an appointment to see Dr. Baldwin on Thursday, August 5, 1999 for another opinion." We interpret such a statement as a contention that claimant was not medically stationary at claim closure.

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981).

The propriety of the closure turns on whether claimant was medically stationary at the time of the April 21, 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12, (1980).

In a June 24, 1999 letter, we requested that the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials.[1] The insurer submitted its response on June 30, 1999, however, no further response has been received from claimant. Therefore, we will proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often, is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant requested review because he was seeking a "second opinion" from another physician. We interpret claimant's request for review as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure. However, the time period for which temporary disability compensation was awarded is incorrect.

The insurer submitted an April 9, 1999 letter from Dr. Matteri, claimant's attending physician, in support of its contention that claimant was medically stationary at the time it closed his claim. Dr. Matteri opined that claimant was medically stationary and that there are "no plans for further follow up." This opinion is unrebutted. Based on this uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed.

In its April 21, 1999 Notice of Closure, the insurer listed the dates temporary disability compensation was awarded as September 16 through October 30, *1986*. In our December 3, 1998 Own Motion Order, we authorized the payment of temporary disability compensation to begin the date claimant was hospitalized for surgery, *i.e.* February 10, *1999*. Dr. Matteri opined that claimant was medically stationary on April 9, *1999*. Thus, on this record, we conclude that claimant was disabled due to his compensable injury from February 10, 1999 until April 9, 1999, and, thus, entitled to temporary

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[1] Given that claimant had expressly mentioned that his "second opinion" appointment was on August 5, 1999, we allowed additional time for claimant to submit further documentation.

disability benefits until that time. *See Frank L. Bush*, 48 Van Natta 1748 (1996). Therefore, we modify the insurer's Notice of Closure to award claimant temporary disability compensation, less time worked, from February 10, 1999 through April 9, 1999.

Accordingly, we modify the insurer's April 21, 1999 Notice of Closure to award claimant temporary disability compensation from February 10, 1999 through April 9, 1999 (less time worked) when he became medically stationary. The April 21, 1999 Notice of Closure is affirmed in all other respects.

IT IS SO ORDERED.

In the Matter of the Compensation of
PENNY A. KELSEY, Claimant
WCB Case No. 98-05272
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of her occupational disease claim for her right shoulder condition. In her brief, claimant contends that ORS 656.802(2)(e) is unconstitutional. 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."

CONCLUSIONS OF LAW AND OPINION

Claimant has a right shoulder condition for which she seeks benefits as an occupational disease. The record contains two medical opinions concerning causation. Both doctors agree that claimant has an impingement syndrome of the right shoulder. (Exs. 16, 23-5). Claimant's treating physician, Dr. Webb, specifically diagnosed right shoulder rotator cuff tendinitis and subacromial bursitis. (Ex. 36). Dr. Baker, the physician who examined claimant on behalf of the insurer, diagnosed a frozen right shoulder with impingement syndrome. (Ex. 23-5). Dr. Baker believed that claimant also had a preexisting condition consisting of hypertrophic change in the right acromioclavicular joint and a type II acromion. (Ex. 23-6).

After reviewing the record, we are not persuaded that claimant has a preexisting condition. We find no persuasive reasons to reject the opinion of claimant's treating physician and surgeon, Dr. Webb. Dr. Webb specifically stated that claimant had no preexisting conditions which contributed to her diagnoses. (Ex. 16-1). Even after the surgery performed on claimant's right shoulder, Dr. Webb continued to opine that "there is nothing else present in [claimant's] development of her right shoulder rotator cuff tendinitis and subacromial bursitis." (Ex. 36). Accordingly, based on his status as claimant's treating doctor, and the only doctor who had the advantage of viewing her condition at the time of surgery, we find Dr. Webb has provided the most persuasive opinion. Therefore, based on that opinion, we conclude claimant does not have a preexisting condition. Accordingly, claimant must prove that employment conditions were the major contributing cause of her right shoulder condition. ORS 656.802(2)(a).[1]

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[1] Because of our conclusion that claimant does not have a preexisting condition, we need not address claimant's argument regarding the constitutionality of ORS 656.802(2)(e).

We also find that Dr. Webb's opinion is persuasive with respect to the issue of causation. We disagree with SAIF's contention that Dr. Webb's opinion is not based on an accurate description of claimant's work activities. Dr. Webb reported that repetitive activity with the shoulder could lead to symptoms of impingement and impingement "can and does develop even when this activity is limited to no more than 90 degrees." (Ex. 40-2). Dr. Webb stated that such a condition occurs "when repetitive activity exceeds 90 degrees of either flexion or abduction, or more in an overhead position." Finally, Dr. Webb reported, "The way I interpret [claimant's] history is that she certainly did elevate at least between, as mentioned above, 60-90 degrees as she performed her necessary work endeavors." (Ex. 40-2).

After reviewing claimant's credible testimony at hearing, we conclude that Dr. Webb had an accurate history. Dr. Webb reported that "when the arm is elevated straight in front of the body such that, when one is standing, the arm is parallel to the ground, then this represents 90 degrees of forward flexion." (Ex. 40-2). When asked to describe her activities at work, such as reaching for and dialing a phone, claimant demonstrated that her hand and forearm were held to about the level of her shoulder or a little bit lower than shoulder level. (Tr. 31-37). Accordingly, we conclude that claimant's testimony is consistent with Dr. Webb's understanding of her job activity.

Finally, we reject the contention that Dr. Baker, the doctor who examined claimant on behalf of SAIF, had an accurate history. Dr. Baker reported that claimant's job involved sitting in a cubical at a keyboard and entering data. Claimant also advised Dr. Baker that she took orders over a telephone console, "which causes her to reach forward with her right arm and shoulder to a very slight degree (she demonstrates about 10 to 12 degrees of forward flexion of [t]he right shoulder as she imitates her right upper extremity motion while dealing with her phone console)." (Ex. 23-2).

Based on his belief that claimant's repetitive activity consisted primarily of reaching 10 to 12 degrees in the flexed position and she almost never reached overhead, Dr. Baker disagreed that work was the major cause of claimant's condition. Dr. Baker stated that, "my experience tells me that impingement syndrome occurs when the individual reaches overhead or at shoulder between 40 and 60 degrees in flexed position." Because his history indicated that claimant seldom obtained that position, Dr. Baker disagreed with Dr. Webb's opinion. (Ex. 37-1).

After reviewing Dr. Baker's opinion, we conclude that it is not based on an accurate history. Although Dr. Baker observed claimant demonstrate her work activity during his exam, we are unable to conclude that the range of motion findings he recorded were accurate. Rather, it follows that, because claimant's demonstrated range of motion at hearing is consistent with the range of motion findings relied on by Dr. Webb, Dr. Baker's opinion is inaccurate and, therefore, not persuasive.

Consequently, based on the persuasive opinion of Dr. Webb, we find that claimant has established that work conditions were the major contributing cause of her right shoulder condition. Therefore, claimant has met her burden of proof, and SAIF's denial must be set aside.

Claimant's counsel is entitled to an assessed attorney fee for services at hearing and on review concerning the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we conclude that a reasonable fee for claimant's counsel's services at hearing and on review is $5,000, to be paid 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 claimant's counsel might not be compensated.

ORDER

The ALJ's order dated February 12, 1999 is reversed. The SAIF Corporation's May 11, 1998 denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an assessed attorney fee of $5,000 for services at hearing and on review, to be paid by SAIF.

In the Matter of the Compensation of
TERRY L. SHEELEY, Claimant
WCB Case No. 98-06011
ORDER ON REVIEW
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) declined to award additional temporary disability between January 2, 1994 and November 15, 1995; (2) declined to award penalties for the insurer's allegedly unreasonable failure to pay temporary disability; and (3) declined to impose "sanctions" for the insurer's alleged failure to provide discovery. On review, the issues are temporary disability, penalties and claim processing.

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

The ALJ found that claimant was not entitled to the disputed temporary disability, finding that no doctor had authorized payment of temporary disability during the relevant period. *See* ORS 656.262(4)(g).[2] We agree with the ALJ that the record contains no contemporaneous temporary disability authorization from an attending physician for the time period from January 2, 1994 through November 15, 1995. (*See* January 20, 1994 letter, Dr. Rischitelli; May 24, 1996 letter, Dr. Baum). Thus, claimant has not established entitlement to temporary disability benefits for that period. *See Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999) (limitations in ORS 656.262(4)(g) apply to both procedural and substantive entitlement to temporary disability).

Claimant also alleges that the insurer intentionally withheld evidence from him. Our review of the record does not establish that the insurer has engaged in such conduct. Thus, we agree with the ALJ that claimant is not entitled to penalties or "sanctions" for an alleged discovery violation.

ORDER

The ALJ's order dated February 25, 1999 is affirmed.

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[1] Claimant has expressed a concern about whether we have received his June 10, 1999 "cross-brief." The Board has received that brief, as well as claimant's May 1999 appellant's brief and the insurer's May 28, 1999 respondent's brief. Based on those briefs, we have proceeded with our review.

[2] ORS 656.262(4)(g) provides:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

In the Matter of the Compensation of
DONNA A. GOODMAN-HERRON, Claimant
WCB Case No. 99-01482
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Otto's order that awarded temporary disability benefits from December 17, 1997 to January 11, 1999. On review, the issues are claim processing and temporary disability benefits. We reverse.

FINDINGS OF FACT

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

In 1994, claimant filed a workers' compensation claim for a psychological condition. Claimant requested a hearing regarding SAIF's denial. The ALJ upheld SAIF's denial. Claimant requested review and the Board affirmed. Claimant petitioned for judicial review. On December 17, 1997, the Court of Appeals reversed the Board's order and remanded for reconsideration.

The Board issued an Order on Remand on October 30, 1998, finding the claim compensable and setting aside SAIF's denial. On November 27, 1998, the Board vacated the Order on Remand to consider SAIF's motion for reconsideration. On January 12, 1999, the Board issued its Second Order on Remand that again found the claim compensable and set aside SAIF's denial.

On February 11, 1999, SAIF petitioned the Court of Appeals for judicial review of the Board's compensability decision. Thereafter, claimant requested a hearing, seeking temporary disability benefits beginning December 17, 1997 (the date of the court's decision).

CONCLUSIONS OF LAW AND OPINION

Applying ORS 656.313, the ALJ held that claimant was entitled to temporary disability benefits beginning December 17, 1997 (the date the court reversed the Board's earlier decision upholding SAIF's denial and remanded for reconsideration). We disagree.

ORS 656.313 states, in pertinent part:

> "(1)(a) Filing by an *employer* or the *insurer* of a request for hearing on a reconsideration order before the Hearings Division, a request for Workers' Compensation Board review or court appeal or request for review of an order of the Director of the Department of Consumer and Business Services regarding vocational assistance stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs." (Emphasis added.)

In order to determine their meaning, we examine the text of the statutes in context, turning to the legislative history only if we cannot discern the meaning of the statutes from that review. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993).

ORS 656.313(1) specifically sets out that an appeal by the *employer* or the *insurer* triggers its application. Because it refers to "temporary disability benefits that accrue from the date of the order appealed," the statute anticipates that the carrier has been ordered through litigation to accept a workers' compensation claim and provide benefits including temporary disability. It further anticipates that compensation is not due and payable until such time as a denial has been set aside. Once an order issues that sets aside a denial of compensability, the insurer must pay certain benefits consistent with the requirements of the statute. *See Pamela S. Cheney*, 44 Van Natta 2100 (1992).

Here, the denial was not set aside until the Board issued the Second Order on Remand on January 12, 1999. Thus, it was not until that date that there existed any order providing temporary disability benefits.[1] SAIF has appealed that decision. It is SAIF's appeal that triggers the application of ORS 656.313. Therefore, claimant was not entitled to any benefits prior to our January 12, 1999 Second Order on Remand that set aside SAIF's denial. All benefits are stayed upon appeal by SAIF, except for temporary disability payments accruing from the date of that order. ORS 656.313(1)(a)(A).[2]

Because we determine that no temporary disability was due and payable prior to the ordered acceptance of the claim, it is unnecessary to address SAIF's objection to claimant's argument that the appeal to the Supreme Court requires SAIF to pay compensation from the date of that appeal.

ORDER

The ALJ's order dated May 26, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded temporary disability compensation from December 17, 1997 to January 11, 1999 and an "out-of-compensation" attorney fee for that period is reversed. The remainder of the ALJ's order is affirmed.

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[1] The Court of Appeals decision did not determine the issue of compensability and set aside SAIF's denial. Instead, the court reversed the Board's earlier decision upholding SAIF's denial and remanded with instructions to determine compensability consistent with *Redman Industries, Inc. v. Lang*, 142 Or App 404 (1996).

[2] The parties stipulated that claimant was entitled to temporary total disability benefits from January 12, 1999 to the present, and a 25 percent penalty based on that compensation as a result of SAIF's unreasonable failure to pay.

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
ORDER OF ABATEMENT
Donald M. Hooton, Claimant Attorney
Larry D. Schucht (Saif), Defense Attorney

Claimant requests reconsideration of our August 20, 1999 Order on Reconsideration that adhered to our May 19, 1999 order that adopted and affirmed the Administrative Law Judge's order upholding the SAIF Corporation's denials of claimant's injury claims for cervical and thoracic conditions. With his motion, claimant has submitted post-hearing medical evidence.

In order to allow sufficient time to consider the motion, our August 20, 1999 order is abated. SAIF is granted an opportunity to respond. To be considered, SAIF's response should be received within 14 days of the date of this order. Thereafter, we will take this matter under advisement.[1]

IT IS SO ORDERED.

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[1] Because it appears that claimant's motion may not have been copied to SAIF's counsel, we have included a copy of claimant's motion and attached documents with SAIF's copy of this order.

In the Matter of the Compensation of
JIM E. HUNT, Claimant
WCB Case Nos. 98-08443, 98-07975, 98-06120 & 97-09473
INTERIM ORDER
Welch, Bruun, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

The self-insured employer has requested review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's right shoulder adhesive capsulitis condition; and (2) set aside its denial of claimant's aggravation claim for a right shoulder condition. Claimant has cross-requested review of that portion of the ALJ's order that upheld the self-insured employer's denial of his claim for C7 radiculopathy.

Subsequent to the requests for Board review, the parties participated in a mediation in an effort to resolve this matter. By letter dated April 19, 1999, Board review was suspended pending the outcome of the mediation. On July 9, 1999, the Board was advised that the mediation was unsuccessful and consequently a revised appellate briefing schedule was implemented.

Thereafter, the employer moved to disqualify claimant's counsel from further participating in this matter. Following receipt of the employer's motion, the Board granted claimant an opportunity to respond. Claimant's response, as well as the employer's reply, have been received. We now proceed to address the employer's motion.

The employer asserts that claimant's counsel, and his firm, should be disqualified from further representation in this matter on the basis that claimant's counsel hired a paralegal who was previously employed by the employer's claims processor. Because of his employment with the employer's claims processor, the employer contends that claimant's counsel's paralegal possessed confidential information concerning claims processing in general, as well as claims processing information specific to claimant.

As noted by the employer, the Board has *de novo* review on appeal. However, the Board's review is based solely on the record developed at the hearing. *See* OAR 438-011-0015(1). The employer's motion contains no assertion that the hearings record was improperly developed as a result of the paralegal's prior employment or that the paralegal was involved with this case prior to the February 19, 1998 hearing. Finally, the issues litigated at hearing involved medical questions. Thus, it is unclear, what effect, if any, the paralegal's prior employment would have on the manner in which the record was developed. Consequently, we find no basis to disqualify claimant's counsel from further participating in this matter.[1]

In any event, the employer has not cited, nor have we found, that the Board has specific authority to disqualify an attorney from representing a party in a workers' compensation case. Moreover, this matter appears to involve a potential allegation of a violation of Oregon State Bar disciplinary rules.[2] To the extent that it does potentially involve such an allegation, jurisdiction lies with professional boards created by the Oregon State Bar Rules of Procedure and the Supreme Court. *See Brown v. Oregon State Bar*, 293 Or 446 (1982).

For these reasons, the employer's motion is denied.

In light of our conclusion, we find it appropriate to reinstate the briefing schedule in this matter. Therefore, the employer's appellant brief must be filed within 21 days from the date of this order. Claimant's respondent's/cross-appellant's brief must be filed within 21 days from the date of mailing of

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[1] Assuming we possessed the authority to disqualify a party's attorney, such a process would likely have to take into account the prejudice to that attorney's client. *See State ex rel Bryant v. Ellis*, 301 Or 633 (1986). Removing claimant's counsel at this late date would appear to prejudice claimant.

[2] We note that claimant's counsel's submission indicates that he has contacted the Oregon State Bar regarding this matter. However, our decision is not based on claimant's counsel's representation of the Bar's response. Rather, as noted above, this appears to be matter between the attorneys and the Bar.

the employer's appellant's brief. The employer's reply/cross-respondent's brief must be filed within 14 days of the mailing date of claimant's respondent's/cross-appellant's brief. Claimant's cross-reply brief must be filed within 14 days of the mailing date of the employer's cross-respondent's brief.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA J. WILLIAMS, Claimant
WCB Case No. 98-06508
ORDER ON RECONSIDERATION (REMANDING)
Floyd H. Shebley, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorneys

On August 12, 1999, we withdrew our July 26, 1999 Order on Review that had affirmed an Administrative Law Judge's (ALJ's) order upholding the insurer's denial of her bilateral hand and arm condition. We took this action to consider claimant's motion for reconsideration. Having received and considered the insurer's response to the motion, we now proceed with our reconsideration.

In affirming the ALJ's order, we agreed that the opinion of Dr. Long was not sufficient to establish compensability. In light of the contrary medical evidence, we were not persuaded by Dr. Long's opinion that claimant had cervical root and cervical cord compromise as a result of C5-6 and C6-7 disc lesions.

On reconsideration, claimant submitted a July 12, 1999 report from Dr. Long that was not available at the time of the February 10, 1999 hearing. Claimant contends that the evidence of substantial improvement in her condition after her "post-hearing" cervical surgery proves that Dr. Long's analysis of causation was correct. She submitted copies of additional "post-hearing" medical records, including chart notes from Dr. Keenen dated May 3, 1999, May 5, 1999, May 14, 1999, May 28, 1999 and June 21, 1999, as well his May 5, 1999 surgical report and a May 8, 1999 discharge summary. On May 3, 1999, Dr. Keenen discussed the risks of surgery with claimant and he performed a C5-6 and C6-7 anterior diskectomy on May 5, 1999. Claimant has submitted three post-surgical reports from Dr. Keenen indicating she was doing well after surgery. Dr. Long's July 12, 1999 report said claimant had substantially improved after the surgery and had very good resolution of her right lower extremity pain. Dr. Long reported that claimant's right upper extremity strength was substantially better than it was in February 1999.

Claimant also submitted copies of a "post-hearing" June 7, 1999 chart note from Dr. Fielder. The chart note from Dr. Fielder concerned a follow-up appointment for claimant's breast carcinoma. Dr. Fielder reported that since claimant's cervical surgery, she had less pain in her neck and had noted marked improvement in numbness of her feet and hands.

Finally, claimant has submitted copies of a "post-hearing" Stipulation and Order and Opinion and Order regarding claims of coworkers who performed the same work activities as claimant. Claimant requests remand to the ALJ for purposes of reopening the record and considering all the new proposed exhibits.

The insurer vehemently objects to claimant's request for remand. The insurer asserts that ample time and consideration were given to the fact that claimant's upper arm complaints may be cervical in nature. The insurer argues that, although claimant's surgical reports could not have been produced at the time of hearing, the causation analysis was already hotly disputed.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. *See Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1983) (Board has no authority to consider newly discovered evidence). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we conclude that a compelling reason has been shown for remanding the case. First, the evidence regarding claimant's cervical surgery concerns her disability, *i.e.*, her bilateral hand and arm condition. The new evidence concerning claimant's cervical surgery was not available or obtainable by the time the record closed on March 11, 1999. The Opinion and Order issued on April 13, 1999 and claimant's cervical surgery was on May 5, 1999.

Moreover, we agree with claimant that the new evidence is reasonably likely to affect the outcome of the case. The ALJ found that Dr. Long's conclusory opinion did not explain how claimant's work postures caused her hand and arm condition. On review, we agreed with the ALJ that Dr. Long's opinion on causation was not sufficient to establish compensability. Furthermore, we were not persuaded by Dr. Long's diagnosis that claimant had C5-6 and C6-7 disc lesions. In reaching that conclusion, we referred to opinions from claimant's previous treating physicians, who had expressed concerns that her symptoms were psychologically-based. After reviewing the proffered evidence regarding the results of claimant's cervical surgery, we agree with claimant that the new evidence regarding causation of her bilateral hand and arm condition is reasonably likely to affect the outcome of the case. *See Parmer v. Plaid Pantry # 54*, 76 Or App 405 (1985) (where evidence regarding the claimant's post-hearing surgery "vindicated" the treating physician's prior opinion, the Board abused its discretion by not remanding the case to the ALJ); *James N. Nappier, Jr.*, 50 Van Natta 2145 (1998) (case remanded for post-hearing MRI report).

On the other hand, we deny claimant's request to remand the case for submission of a post-hearing Stipulation and Order and Opinion and Order regarding claims of her coworkers. The Stipulation and Order submitted by claimant concerns a claim for a cervical condition from Ms. Seifert, one of claimant's coworkers. Ms. Seifert testified at claimant's hearing and had an opportunity to discuss her work activities, which were similar to those of claimant. Ms. Seifert said she needed shoulder surgery "due to respooling." (Tr. 57). We find that the proffered evidence is essentially cumulative of the evidence already in the record. Moreover, we are not persuaded that the Stipulation and Order concerning Ms. Seifert's case is reasonably likely to affect the outcome of this case.

The Opinion and Order submitted by claimant on reconsideration concerns an occupational disease claim for a cervical condition filed by Ms. Fray, claimant's coworker. At claimant's hearing, Ms. Fray testified about her work activities, which were similar to those of claimant. Ms. Fray was not asked if she had any work-related injuries or had filed any claims. The Opinion and Order concerning Ms. Fray's case that was submitted by claimant on reconsideration shows that Ms. Fray's attorney was also claimant's attorney. Although the decision in Ms. Fray's case was not available at the time of claimant's hearing, we are not persuaded that the information that Ms. Fray had apparently sustained a cervical condition as a result of her work activities was not obtainable at the time of hearing. Furthermore, we are not persuaded that the Opinion and Order regarding Ms. Fray's case is reasonably likely to affect the outcome of this case.

In sum, we find that the case should be remanded to ALJ Lipton for the taking of additional evidence regarding claimant's recent cervical surgery, including Dr. Long's July 12, 1999 report, Dr. Keenen's chart notes dated May 3, 1999, May 5, 1999, May 14, 1999, May 28, 1999 and June 21, 1999, as well as his May 5, 1999 surgical report and May 8, 1999 discharge summary, and Dr. Fielder's June 7, 1999 chart note. On remand, the ALJ shall allow the insurer an opportunity to cross-examine or rebut the proffered evidence. The submission of this additional evidence shall be made in any manner that the ALJ determines will achieve substantial justice. Following these further proceedings, the ALJ shall issue a final, appealable order concerning the issues raised in this case.

Accordingly, on reconsideration of our prior order, the ALJ's order dated April 13, 1999 is vacated. This matter is remanded to ALJ Lipton for further action consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTT ANDERSEN, Claimant
WCB Case No. 98-04731
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Wallace Klor & Mann, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of claimant's current left shoulder condition. Claimant also moves to reopen the record to admit additional evidence. On review, the issues are remand and compensability.

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

On review, claimant provides a report from claimant's treating physician, Dr. Brenneke, and seeks to reopen the record for admission of the document. Our review must be based on the record certified to us. *See* ORS 656.295(5). Thus, we treat such submissions as a motion to remand to the ALJ for the introduction of additional evidence. *See Judy A. Britton*, 37 Van Natta 1262 (1985).

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

Here, Dr. Brenneke's report is dated April 21, 1999, after the March 31, 1999 hearing and April 7, 1999 Opinion and Order. Along with the report, claimant submits copies of medical articles. Other than stating that Dr. Brenneke was not available to testify at hearing and was available only for deposition at certain times, claimant's attorney provides no explanation for his failure to procure and submit Dr. Brenneke's report at the time of hearing. That is, although counsel may have explained why Dr. Brenneke was not available to testify at hearing, he does not give any explanation for not obtaining and making the report available for submission at hearing.

Consequently, we conclude that claimant has failed to show that the report and accompanying articles were not obtainable at the time of hearing. Accordingly, claimant has not demonstrated a "compelling reason" to remand the case to the ALJ for admission of the additional evidence. *See, e.g., Lonnie L. Colbray, Sr.*, 51 Van Natta 129 (1999) (no remand to admit report generated after hearing in part because no showing that report was not obtainable at the time of hearing).

ORDER

The ALJ's order dated April 7, 1999 is affirmed.

In the Matter of the Compensation of
EDWIN W. PROPPER, Claimant
WCB Case No. 98-08556
ORDER ON REVIEW
Martin Alvey, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that awarded 4 percent (6 degrees) scheduled permanent disability for loss of use or function of each forearm (wrist), whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In awarding 4 percent for each of claimant's wrists, the ALJ relied on claimant's range of motion as reported by Dr. Van Allen, the medical arbiter. Based on the following reasoning, we disagree.

Impairment is established by a preponderance of medical evidence, considering the attending physician's and medical arbiter's findings. *Koitzsch v. Liberty Northwest Ins. Corp.*, 125 Or App 666 (1994); *Roseburg Forest Products v. Owen*, 129 Or App 442 (1994). The findings of an insurer-arranged medical examiner may be considered if ratified by the attending physician. *Owen*, 129 Or App at 445. We rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *Carlos S. Cobian*, 45 Van Natta 1582 (1993).

In this case, considering impairment as it relates to the compensable injury, no physician found any loss of range of motion. Dr. Nolan, an insurer-arranged medical examiner, determined that claimant's range of motion was normal. Dr. Rosenbaum, the attending physician, concurred with Dr. Nolan's conclusion.

Dr. Van Allen, the medical arbiter, reported decreased range of motion findings for claimant's wrists. Nonetheless, Dr. Van Allen concluded as follows:

> "I feel the patient has no measurable impairment in my opinion secondary to the accepted condition of carpal tunnel syndromes. The patient certainly does not have normal hands with some degenerative changes which would be unrelated to the accepted condition and could be further evaluated by radiographs. Certainly he may require further evaluation for his hands, but in my opinion the complaints are unrelated to his accepted condition."

(Ex. 21, at 2).

Based on this conclusion, we do not consider Dr. Van Allen's reduced range of motion findings to be related to claimant's compensable injury. *See Kenneth W. Emerson*, 51 Van Natta 654 (1999). Rather, Dr. Van Allen's later comments suggested attribution of impairment to other causes. Alternatively, even if we considered Dr. Van Allen's findings to be due to the compensable injury, we would find them unpersuasive in light of Dr. Van Allen's ultimate conclusion that claimant sustained no measurable impairment due to the accepted condition. Therefore, the record does not establish that claimant has any permanent impairment due to his bilateral carpal tunnel syndrome condition. Consequently, he is not entitled to a scheduled permanent disability award.

ORDER

The ALJ's order dated April 20, 1999 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

In the Matter of the Compensation of
TERRY L. TOWNSEND, Claimant
WCB Case No. 98-06674
ORDER DENYING RECONSIDERATION
Stebbins & Coffey, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of our August 25, 1999 order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of claimant's cervical injury claim. Specifically, claimant contends that we erred in rejecting attending physician Dr. Bert's opinion concerning causation.

Having fully considered the insurer's contentions, we have nothing further to add to our prior decision.[1] Accordingly, claimant's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our August 25, 1999 order.

IT IS SO ORDERED.

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[1] Claimant also asserts that the absence of an opinion on review in effect compromises its confidence that the matter received the attention it requires. Based on the following reasoning, any such concerns would be ill-founded.

In considering each case presented for review, the Board conducts a thorough and methodical review of the record, which necessarily includes the ALJ's order and the parties' respective written arguments on review. Pursuant to ORS 656.295(6), the Board may affirm, reverse, modify or supplement the ALJ's order and make such disposition of the case as it determines to be appropriate. While particular orders of the Board may provide instructional value for the parties, the primary purpose of Board review and the resulting order is to adjudicate the parties' dispute. *See e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997) (by adopting an ALJ's order, the Board agrees with the facts and conclusions contained in the ALJ's order and considers the ALJ's order to be sufficient for appellate review).

In the Matter of the Compensation of
DAVID L. CONNER, Claimant
Own Motion No. 66-0455M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's June 22, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from November 19, 1998 through June 1, 1999. SAIF declared claimant medically stationary as of June 1, 1999.

In an August 6, 1999 letter, we requested SAIF to submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. SAIF submitted its response on August 10, 1999. Claimant has not submitted a response to SAIF's submission. Therefore, we proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of a carrier's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issued raised less often is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Claimant does not contend that his medically stationary date is incorrect or that he was not medically stationary when SAIF closed his claim. In any event, the record would not support such a contention.[1] Rather, claimant seeks reinstatement of his temporary disability compensation or in the alternative, for an "award" to enable him to "retrain myself into an occupation without the physical demands of my current work."

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 question is "yes." Thus, even if claimant were contesting his medically stationary date, based on the uncontroverted medical evidence (see footnote 1), we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed or that he was entitled to additional temporary disability beyond June 1, 1999.

Regarding claimant's request for an "award," we interpret him to be asking us to grant other workers' compensation benefits. We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990).

Thus, 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. We further determine that he is not entitled to additional disability benefits (temporary or permanent). Accordingly, we affirm SAIF's June 22, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] In this regard, Dr. Waldram, claimant's attending physician, provided the only medical evidence regarding claimant's medical stationary status. Following a closing examination on June 1, 1999, Dr. Waldram indicated that claimant was considered "stable and stationary" as of that date. Dr. Waldram's opinion is unrebutted. Further, there is no evidence that claimant was not medically stationary at the time his claim was closed on June 22, 1999.

In the Matter of the Compensation of
JAMES M. KING, Claimant
Own Motion No. 99-0248M
OWN MOTION ORDER
Ransom & Gilbertson, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's compensable heart condition. Claimant's aggravation rights expired on August 4, 1983. SAIF agrees that claimant's current condition is causally related to the compensable condition, that it is responsible for claimant's current condition and that the proposed surgery or hospitalization is reasonable and necessary. However, SAIF contends that claimant was not in the work force at the time of the current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of the current disability. In response to SAIF's contention, claimant submits an affidavit, stating that "If not for the fact that I have a compensable workers[']compensation injury, I would be gainfully employed at this time." Further, SAIF submitted a transcript of an interview with claimant which states that, although he has been on Social Security benefits since 1988 or 1989, he returned to work in 1997 and quit in February of 1999 because of "his heart problems." Based on his affidavit and his SAIF interview, we are persuaded that claimant was willing to work.

However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to his May 9, 1999 hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

Claimant indicates that he left work in February of 1999 because he was "always out of breath with the least amount of physical exertion." He attributes being "out of breath" to his compensable heart condition. However, claimant does not submit a medical opinion supporting his contentions. The record does not contain medical evidence that claimant was taken off work in February 1999 due to his compensable injury. Dr. Goldberg, claimant's attending physician, opined that claimant was "disabled from the time of his hospitalization in May 9, 1999." Thus, although unable to work at the time of his actual hospitalization, the medical documentation contained in the record fails to establish that *prior* to his May 9, 1999 hospitalization, claimant was unable to work and that it would have been futile for him to seek work due to his compensable condition.

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

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

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

IT IS SO ORDERED.

September 24, 1999 Cite as 51 Van Natta 1535 (1999)

In the Matter of the Compensation of
RONALD E. SULLIVAN, Claimant
Own Motion No. 98-0229M
OWN MOTION ORDER
Ernest M. Jenks, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's compensable cervical condition. Claimant's aggravation rights expired on October 14, 1993. The insurer opposed reopening of claimant's claim contending that: (1) claimant's current condition was not compensably related to his accepted injury; (2) the insurer was not responsible for claimant's current condition; and (3) claimant was not in the work force at the time of his disability.

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

On October 8, 1998, we consolidated this own motion matter with a hearing pending in WCB Case No. 98-07349. We took this action because there were issues pending regarding the compensability of claimant's current condition. Additionally, we requested that the assigned Administrative Law Judge (ALJ) make findings of fact regarding claimant's work force status.

On April 26, 1999 ALJ Otto approved a "Stipulation and Order," which resolved the parties' dispute regarding the compensability of claimant's current cervical condition. The parties agreed that claimant's current condition was a compensable component to his 1986 own motion claim. The Stipulation resolved the compensability issue, but did not address claimant's work force status.

In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (3) not working but willing to work, *and* is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Following the submission of the aforementioned stipulation, we requested the parties' positions regarding claimant's work force status. In response to our inquiry, claimant's attorney asserted that "claimant withdraws his request for review related to time loss compensation."

Accordingly, we conclude that claimant has withdrawn his request for Own Motion relief (in other words, he is not seeking temporary disability benefits). Therefore, the request for own motion relief is dismissed.

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
LARRY A. CADWELL, Claimant
WCB Case No. 98-09649
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that affirmed an Order on Reconsideration that awarded claimant no additional scheduled permanent disability for his bilateral knee condition. On review, the issue is extent of scheduled permanent disability.

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

On review, claimant argues that this case is controlled by our decision in *Jonathan E. Grant*, 47 Van Natta 1709 (1995). In *Grant*, the claimant had previously received an award of 13 percent unscheduled permanent disability based on surgery and loss of range of motion. Following the award, the claimant's condition worsened and he underwent surgery at different levels that resulted in additional loss of range of motion. The ALJ found that the claimant had lost additional earning capacity since the prior claim closure and awarded the claimant 6 percent unscheduled permanent disability. On review, we found that the claimant's current disability, without consideration of his prior 13 percent award, was 10 percent. On review, we found that the claimant was not entitled to be doubly compensated for a permanent loss of earning capacity that existed prior to his compensable aggravation. We concluded that, after considering the claimant's prior award, we were not persuaded that the claimant was entitled to unscheduled permanent disability beyond the 6 percent granted by the ALJ's order.

Here, claimant argues that, by affirming the ALJ's order in *Grant*, we agreed that the claimant was entitled to an additional award of 6 percent because the amount represented impairment of a type that was not present at the time of the initial closure. Claimant reads too much into our order in that case. The carrier withdrew its cross-request for review of that case and, accordingly, there was no reason for a reduction in the amount awarded by the ALJ. Moreover, in light of the fact that there was no cross-request for review, our order did not reach a conclusion with respect to what the actual award would be after considering the claimant's prior award. Rather, we merely affirmed the ALJ's order as we did not find that the claimant was entitled to an additional award. Finally, we note that, in *Grant*, the ALJ found that claimant had lost "additional earning capacity" since the prior claim closure. In this case, however, the ALJ found, and the parties agree, that claimant's *total* impairment following his aggravation was less than the amount previously awarded. Under the circumstances, we find that *Grant* is distinguishable, and we affirm the ALJ's order.

ORDER

The ALJ's order dated May 10, 1999 is affirmed.

In the Matter of the Compensation of
DENNIS D. HALL, Claimant
WCB Case Nos. 98-04154, 98-03816 & 97-10410
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the SAIF Corporation's denial, on behalf of Mt. Hood Metals, Inc., of claimant's right knee chondromalacia condition; and (2) upheld SAIF's partial denial, on behalf of Frank Wade, a noncomplying employer,[1] of the same condition. On review, the issues are compensability and responsibility.[2] We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and summarize the relevant facts as follows.

Claimant injured his right knee while living in another state in 1977. In February 1978, claimant moved to Oregon and sought treatment for severe right knee pain in March 1978.

On June 4, 1986, claimant compensably injured his right knee while working for Mt. Hood Metals which was insured by SAIF. The claim was accepted for a right knee sprain. Claimant underwent right knee surgery for a medial meniscus tear by Dr. Irvine in July 1986. The claim was closed by Determination Order in March 1987 with an award of 5 percent scheduled permanent disability. Claimant was awarded an additional 5 percent scheduled permanent disability in a September 1987 Opinion and Order.

On February 6, 1997, claimant compensably injured his right knee while working for Frank Wade, a noncomplying employer. Claimant underwent right knee surgery by Dr. North on May 22, 1997 for a tear of the medial meniscus. SAIF, as the processing agent for the noncomplying employer, accepted "tear of the peripheral rim of the medial meniscus of the right knee." Claimant's claim was closed by a Notice of Closure in September 1997 with an award of 12 percent scheduled permanent disability.

Claimant requested acceptance of the additional condition of chondromalacia of the femoral and medial condyles of the right knee. Both carriers denied compensability and responsibility.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not established compensability of his right knee chondromalacia because the condition did not require any medical treatment or cause disability. On review, claimant argues that the condition did require treatment and cites portions of the depositions of Drs. Irvine and North.

The cause of claimant's right chondromalacia condition and whether it resulted in disability or a need for treatment are complex medical questions, the resolution of which requires expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967). Both Dr. Irvine and Dr. North offered opinions regarding claimant's right knee chondromalacia.

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[1] After the date of hearing, Johnston & Culberson Inc. became the processing agent for Frank Wade, the noncomplying employer. The Department of Justice submitted the Respondent's brief on behalf of Johnston & Culberson and the Workers' Compensation Division. Although SAIF issued the denial on behalf of Frank Wade and the Division, it is no longer the processing agent for the noncomplying employer claim.

[2] The Board has consolidated this case for review with WCB Case No. 97-08248 because the exhibits in both cases are contained in one record. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), aff'd 139 Or App 512 (1996) (as a general rule, Board will consolidate matters that are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together).

In his deposition testimony, Dr. Irvine stated that, in the context of claimant's post-surgery right knee and activities, the chondromalacia contributes to claimant's need for treatment. (Ex. 79-33). Dr. North also recommended treatment for the chondromalacia in that he advised modification of activities, avoiding use of excessive weights, using ice, exercises to strengthen the leg and non-narcotic medication. Under such circumstances, we find sufficient evidence that the chondromalacia condition necessitated medical treatment. Thus, we disagree with the ALJ's reasoning for upholding the carriers' denials.

Dr. North opined that the 1986 and 1997 injuries and the work activities subsequent to 1986 were the major contributing cause of the chondromalacia. Dr. North thought that the chondromalacia condition preexisted the 1986 injury. He deferred to Dr. Irvine on the question of whether the condition had pathologically worsened between the 1986 surgery and the 1997 injury.

Dr. Irvine opined that there had been no progression of the chondromalacia between the 1986 injury and surgery and the 1997 surgery by Dr. North. Dr. Irvine opined that the 1986 injury was the major contributing cause of the chondrosis.

In analyzing the compensability issue, we find Dr. Irvine's opinion that the major contributing cause of the condition was the 1986 injury to be most persuasive. In this regard, Dr. Irvine was able to compare his 1986 operative findings with photographs of claimant's right knee during the 1997 surgery. Based upon this comparison, Dr. Irvine opined that there was no progression of the chondromalacia between the 1986 surgery and 1997. Because there was no progression of the condition, we are not persuaded by Dr. North's opinion that the 1997 injury and work activities after 1986 contributed to the condition. In addition, we find that because he was able to view both the 1986 surgery and photographs of the 1997 surgery, Dr. Irvine was in the best position to address the cause and progression of the chondromalacia. Thus, we find Dr. Irvine's opinion that the 1986 injury was the major contributing cause of the chondromalacia to be persuasive. Under such circumstances, we conclude that claimant had established compensability of his right knee chondromalacia as a consequential condition under ORS 656.005(7)(a)(A).

Having found the condition compensable as a consequential condition, we conclude, relying on *Conner v. B & S Logging*, 153 Or App 354 (1998), that SAIF/Mt. Hood Metals, Inc. is responsible. We previously applied *Conner* in *Terry J. Rasmussen*, 51 Van Natta 1287 (1999). *Rasmussen* involved a claimant who had an accepted 1982 claim with SAIF for a left knee injury and a 1997 accepted claim for a left knee strain with Kemper. When the claimant required surgery for a degenerative condition, Kemper denied compensability and responsibility and SAIF denied responsibility.

We noted, in *Rasmussen*, that we had applied *Conner* in *Albert H. Olson*, 51 Van Natta 685 (1999). In *Olson*, we explained that we first determine whether the current condition has been previously accepted; if so, then responsibility is decided under ORS 656.308(1). If not, then responsibility is resolved under the presumption in *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), or ORS 656.005(7)(a)(A), depending on whether the medical evidence establishes that a prior accepted injury is the major contributing cause of a consequential condition. 51 Van Natta at 687. Applying this analysis in *Rasmussen*, we determined that the condition at issue had not been accepted and that, therefore, ORS 656.308(1) did not apply. We then determined that the claimant's current left knee condition was a compensable consequential condition of the 1982 SAIF claim. On this basis, we concluded that SAIF was responsible for the claimant's left knee condition.

Here, there has been no prior accepted claim for chondromalacia of the right knee. Because we have found that claimant's right knee chondromalacia condition is a compensable consequence of the 1986 SAIF claim, we find that SAIF is the responsible carrier.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated January 5, 1999 is reversed in part and affirmed in part. That portion of the ALJ's order that upheld SAIF's denial, on behalf of Mt. Hood Metals, Inc., is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded $4,500, payable by SAIF.

September 24, 1999 Cite as 51 Van Natta 1539 (1999)

In the Matter of the Compensation of
DENNIS D. HALL, Claimant
WCB Case No. 97-08248
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) calculated claimant's rate of temporary total disability benefits based on an average weekly wage of $500 per week; and (2) assessed a 5 percent penalty for SAIF's allegedly unreasonable payment of temporary disability (TTD) benefits. Claimant cross-requests review of that portion of the ALJ's order that awarded a 5 percent penalty. Claimant seeks an increase in the penalty to 25 percent. On review, the issues are rate of temporary total disability and penalties.[1] We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Total Disability

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

Penalty

The ALJ assessed a 5 percent penalty for an allegedly unreasonable calculation of TTD benefits. At hearing, claimant's counsel indicated that claimant was not contending that SAIF's calculation of the TTD was unreasonable. Instead, claimant argued that the TTD was untimely paid. (Tr. 15).

The carrier shall be liable for penalties when it "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). Deciding if a carrier acted unreasonably depends on whether, in light of all the evidence available to it, the carrier had a legitimate doubt as to its liability. *Brown v. Argonaut Ins. Co.*, 93 Or App 588, 590 (1988).

Here, it was apparently claimant's theory that because the TTD was miscalculated, it was not timely paid. (In other words, according to claimant's argument, because of SAIF's incorrect calculation of the TTD rate, only a portion of the TTD was timely paid and the rest was still due and owing at the time of hearing when the ALJ found that the rate should have been higher). However, claimant, through his attorney, expressly stated that claimant did not take the position that SAIF's *calculation* of claimant's TTD was unreasonable. If the calculation of the rate of temporary disability benefits was not unreasonable, we have difficulty finding that SAIF's alleged untimely payment based upon its calculation of the rate was unreasonable. In addition, although SAIF, as the ALJ found, did not follow

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[1] This case was consolidated for review with WCB Case Nos. 98-04154, 98-03816 and 97-10410 because the exhibits in both cases are contained in one record. *See, e.g. Greg V. Tomlinson*, 47 Van Natta 1085 (1995), aff'd 139 Or App 512 (1996) (as a general rule, Board will consolidate matters that are so inextricably intertwined that substantial justice and administrative efficiency dictate that the cases be reviewed together).

the administrative rule in calculating the TTD rate, SAIF could have relied on the noncomplying employer's statements and calculated the rate at an even lower rate. On this basis, we are persuaded that SAIF had a legitimate doubt regarding its responsibility to pay the higher TTD rate. Accordingly, given all of the circumstances, we conclude that claimant is not entitled to a penalty for an unreasonable calculation of the TTD rate.

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 $750, 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 September 14, 1998 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a 5 percent penalty is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded $750, payable by SAIF.

In the Matter of the Compensation of
DIANN C. HARRY, Claimant
WCB Case No. 98-06313
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's right shoulder condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the third paragraph on page 2, we replace the third sentence with the following: "Claimant was treated by Dr. Thomas on one occasion in November 1997. Dr. White, claimant's internal medicine physician since 1994, began treating her for shoulder complaints in December 1997." In the fifth paragraph on page 2, we change the citation after the second sentence to read: "(Exhibit 28)."

After reviewing the record, we agree with the ALJ's reasoning and conclusion. We write to address the insurer's argument regarding the onset of claimant's right shoulder complaints. The insurer asserts that claimant's testimony that her right shoulder complaints began in May 1997 is incorrect. The insurer contends that Dr. Manley incorrectly believed that claimant's right shoulder complaints began while she was working.

Claimant testified that she began to notice problems with her right shoulder when she returned to work in May 1997. (Tr. 11). On cross-examination, claimant agreed that she did not have any right shoulder complaints from early 1997 until she went back to work. (Tr. 21).

The medical records, however, indicate that claimant began experiencing some minimal right shoulder symptoms in February 1997. Dr. Manley reported on February 3, 1997 that claimant was developing some subacromial pain in her right shoulder because of use. (Ex. 28). In a deposition, Dr. Manley said he first treated claimant for right shoulder problems on February 3, 1997. (Ex. 82-12). He agreed there was no particular change in her complaints from February 1997 to summer 1997. (*Id.*) On June 16, 1997, Dr. Manley reported that claimant was back to work and was developing a problem with her right shoulder, which he suspected was "very directly related to the left shoulder and is overuse[.]" (Ex. 40). In a later report, Dr. Manley agreed it was medically probable that the "overuse of the right shoulder (which was the direct consequence of the left shoulder injury) [was] the major contributing cause of the right shoulder combined condition[.]" (Exs. 79, 82-22).

We find that claimant's contemporaneous reporting regarding the onset of symptoms is more likely accurate than her recollection at hearing. Thus, to the extent there are inconsistencies, we rely on the contemporaneous medical records. In particular, we find that Dr. Manley had an accurate history of the onset of claimant's right shoulder symptoms and we agree with the ALJ that Dr. Manley's opinion is persuasive.

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

ORDER

The ALJ's order dated May 5, 1999 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

In the Matter of the Compensation of
CONSTANCE D. WILBOURN, Claimant
WCB Case No. 98-09022
ORDER ON REVIEW
Heather Holt, Claimant Attorney
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) upheld the insurer's "back up" denial of claimant's previously accepted right knee lateral meniscus tear; (2) upheld the denial of Grade III condromalacia, rheumatoid arthritis and leg length discrepancy; and (3) declined to award an attorney fee. On review, the issues are the propriety of the back up denial, compensability and attorney fees.

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

Claimant, age 39 at the time of hearing, worked for the employer restaurant as a waitress. On or about June 6, 1998, she experienced the onset of pain and weakness in her right knee as she ascended and descended some stairs to pick up and deliver drinks to customers. She first sought treatment on June 8, 1998. Dr. Venes diagnosed a probable lateral meniscus tear of the right knee.

On August 12, 1998, Dr. Venes referred claimant to Dr. Cronin for an orthopedic evaluation. Dr. Cronin diagnosed significant internal derangement of the right knee, most likely a lateral meniscus tear. He recommended a diagnostic arthroscopy.

On August 26, 1998, the insurer accepted a nondisabling right knee lateral meniscus tear. The next day, Dr. Cronin performed a diagnostic arthroscopy and arthroscopic surgery. His surgical findings included a "very complex tear" out to the periphery of the anterior horn of the lateral meniscus and "some grade III chondromalacia of the anterolateral portions of the lateral femoral condyle." Because claimant's right knee tissue showed evidence of degenerative arthritis, the pathologist recommended ruling out rheumatoid arthritis.

On August 31, 1998, the insurer reclassified claimant's claim to a disabling injury. The next day, Dr. Cronin opined that claimant's cartilage tear related to her work injury and not to any possible rheumatoid arthritis.

On October 13, 1998, claimant was examined by Dr. Schilperoort at the insurer's request. Dr. Schilperoort also reviewed claimant's medical records, including the operative and pathology reports. He concluded that claimant's complex lateral meniscus tear was degenerative in nature and unrelated to an on-the-job injury. He also opined that the chondromalacia noted in the operative report preexisted, and was unrelated to, any on-the-job injury. Dr. Schilperoort further noted that the described mechanism of injury (ascending stairs) would not create a force sufficient to tear an otherwise healthy meniscus, especially because claimant did not describe any tearing episode or specific injury.

Following receipt of Dr. Schilperoort's report, the insurer issued a "back up" denial of claimant's right knee lateral meniscus tear on October 27, 1998. The insurer also denied the compensability of claimant's grade III chondromalacia, as well as a leg length discrepancy and possible rheumatoid arthritis.

On February 9, 1999, Dr. Cronin opined that claimant's meniscal tear was not typical of a degenerative tear and was traumatic in nature. He also related claimant's chondromalacia to the tear and disputed Dr. Schilperoort's finding of a leg length discrepancy.

Dr. Dordevich reviewed claimant's medical records at the insurer's request in February 1999. He concluded that claimant did not sustain any specific knee injury at work, that the complex tear described by Dr. Cronin was typical of a degenerative tear rather than a traumatic injury and that claimant's grade III chondromalacia was long-standing and preexisted the work incident in early June 1998.

In upholding the insurer's denials, the ALJ found that a preponderance of the evidence established that claimant had a preexisting, underlying degenerative condition in her right knee that was the major contributing cause of her lateral meniscus tear.

On review, claimant first contends that the insurer's "back up" denial was impermissible because it was not based on "later obtained evidence." Like the ALJ, we find to the contrary.

Under ORS 656.262(6)(a), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable or the carrier is not responsible, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on the "back-up" denial, the carrier has the burden of proving by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim. The requirement of "later obtained evidence" in ORS 656.262(6)(a) refers to new material, *i.e.*, something other than the evidence that the carrier had at the time of the claim acceptance. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 286 (1993). But a reevaluation of known evidence, for whatever reason, does not constitute "later obtained evidence" under the statute. *Id. See also Ralph E. Murphy*, 45 Van Natta 725 (1993) (evidence in support of a "back-up" denial must be obtained or discovered after acceptance of the claim).

Here, at the time the insurer accepted the claim on August 26, 1998, both Dr. Venes and Dr. Cronin had diagnosed a lateral meniscus tear related to claimant's work activity of ascending stairs. Neither physician had identified any preexisting, underlying condition of claimant's right knee. It was not until after the insurer had accepted the lateral meniscus tear that it received Dr. Cronin's August 27, 1998 operative report describing a "very complex tear" and findings of grade III chondromalacia and the pathology report describing evidence of degenerative osteoarthritis. Because these reports, and the subsequent evaluation and report of Dr. Schilperoort (that related claimant's tear to a degenerative condition rather than a traumatic injury) were not available to the insurer when it accepted the claim, the reports constitute "later obtained evidence" within the meaning of ORS 656.262(6)(a).[1]

Claimant next contends that, even if the insurer's denial was appropriately based on later obtained evidence, the insurer has not proven by a preponderance of the evidence that her claimed lateral meniscus tear is not compensable. We disagree.

Where, as here, the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259 (1986). After considering the causation opinions in the record, we are most persuaded by the opinions of Drs. Schilperoort and Dordevich. Both doctors had an accurate understanding as to the onset of claimant's symptoms. Both doctors opined that the alleged mechanism of injury, ascending stairs, was insufficient to cause a lateral meniscus tear in the absence of a preexisting degenerative condition of the right knee.

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[1] We acknowledge that the insurer issued an amended acceptance reclassifying the claim as disabling on August 31, 1998, four days after claimant's surgery. There is no evidence in the record establishing when the insurer received the operative and pathology reports. But, even assuming that the insurer was aware of the contents of these two reports when it reclassified the claim on August 31, that does not alter the fact that these reports were generated and received after the original claim acceptance. Indeed, as we explained in *Woodrow J. Evans*, 51 Van Natta 1384 (1999), a reclassification of a previously accepted claim does not constitute a new acceptance. Therefore, the August 27, 1998 surgical findings and operative report constitute later obtained evidence. *See CNA Ins. Co. v. Magnuson*, 199 Or App at 286 ("The legislature intended that evidence warranting a retroactive denial 'come about' after the insurer's original acceptance.")

Both doctors concluded, based upon Dr. Cronin's operative report describing a very complex tear and the pathology report documenting degenerative condition, that claimant's lateral meniscus tear was caused in major part by the preexisting degenerative process.

At hearing, Dr. Schilperoort confirmed his opinion that claimant's tear was not caused in major part by the act of ascending and descending stairs at work on June 6, 1998, because that activity, without more, would not impose sufficient stress or force on the knee. He testified that Dr. Cronin's operative findings, describing a complex tear out to the periphery, are consistent with a degenerative tear as opposed to a traumatic injury, as is the pathology report describing findings of degenerative osteoarthritis. In addition, Dr. Schilperoort explained that, because chondromalacia is an evolutionary process that takes considerable time to develop, it was medically probable that the grade III chondromalacia documented during claimant's August 27, 1998 surgery preexisted her onset of symptoms on June 6, 1998.

Although Dr. Cronin had the opportunity to visualize claimant's tear during the arthroscopy, his causation opinion is unpersuasive because it is inconsistent and lacking in explanation and analysis. Indeed, on his initial consultation with claimant in August 1998, Dr. Cronin noted that her symptoms developed while ascending stairs and without specific injury or trauma (*see* Ex. 7-2). But, in February 1999, in rendering an opinion as to the cause of claimant's lateral meniscus tear, Dr. Cronin indicated that she experienced a traumatic work injury. (Ex. 21). He did not further describe the mechanism of that injury, however. Dr. Cronin also opined that claimant's "very complex tear out to the periphery" appeared traumatic and was not typical of a degenerative tear. But, in the absence of any further explanation for this conclusion, we find it less persuasive than the contrary assessments of Drs. Schilperoort and Dordevich.

Consequently, we agree with the ALJ that the insurer has proven, by a preponderance of the evidence, that claimant's lateral meniscus tear is not compensable. Furthermore, on this record, claimant has not established that her chondromalacia is compensable. In this regard, we are persuaded by the opinions of Drs. Schilperoort and Dordevich that the chondromalacia preexisted the June 6, 1998 work incident and was not affected by claimant's work activity on that day.

Finally, contrary to claimant's contention, her attorney is not entitled to an attorney fee with regard to the insurer's denial of rheumatoid arthritis and leg length discrepancy. Because claimant did not make a claim for either condition, those portions of the insurer's denial are a nullity and have no legal effect. *See Stephenson v. Meyer*, 150 Or App 300, 304 (1997) (because no claim was made, the legal predicate for an award of attorney fees did not exist). Furthermore, as the ALJ noted, the medical evidence does not establish the existence of either condition. Therefore, no fee is warranted. ORS 656.386(1).

ORDER

The ALJ's order dated April 15, 1999 is affirmed.

In the Matter of the Compensation of
LARRY J. MORGAN, Claimant
WCB Case Nos. 98-09689 & 97-09267
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On August 25, 1999, we affirmed an Administrative Law Judge's (ALJ's) order that reduced claimant's unscheduled permanent disability award for a head injury from 14 percent (44.8 degrees), as awarded by an Order on Reconsideration, to zero. Contending that we erroneously interpreted a previous ALJ's "compensability" decision and improperly imposed a burden of proof on claimant, he seeks reconsideration of our order.

In order to further consider claimant's contentions, we withdraw our August 25, 1999 order. The insurer is granted an opportunity to respond. To be considered, that response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JENNIFER WILLARD, Claimant
WCB Case No. C991944
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Kasia Quillinan, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Phillips Polich.

On August 12, 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 4 paragraph number 19, the CDA provides: "Claimant agrees that $25 shall be withheld" from the settlement and paid to claimant's attorney for costs advanced to claimant. That provision also states that claimant shall receive the net sum of $2,975.

On August 18, 1999, we wrote the parties explaining that a CDA cannot contain an assignment of proceeds for reimbursement of "costs." ORS 656.234 (moneys payable under Chapter 656 are not subject to assignment prior to their receipt by the claimant); *Debbie K. Ziebert*, 44 Van Natta 51 (1992) (CDA providing for payment of costs to the claimant's counsel disapproved as unreasonable as a matter of law). In accordance with ORS 656.234 and *Ziebert*, we stated that, as drafted, the CDA could not be approved.

On September 9, 1999, we received an addendum to the parties' CDA. As originally submitted, the CDA had provided for a total consideration of $4,000, with $3,000 payable to claimant and $1,000 payable to claimant's attorney. By their addendum, the parties changed the consideration to $1,795.20 with $1,346.40 being paid to claimant and $448.80 to claimant's attorney as a fee. The parties, however, *did not remove or alter paragraph 19 on page 4 of the CDA*. That provision still provides for deduction of costs from the CDA proceeds and still provides that claimant will receive $2,975 (the $3,000 original amount to be paid to claimant minus $25 in costs advanced).

Because the parties revised all other portions of the CDA to reflect the new consideration of $1,795.20, and because that entire sum is either payable to claimant or to her counsel as an "attorney fee," we are persuaded that no portion of the CDA proceeds is payable to claimant's counsel as a reimbursement for "costs." In other words, we interpret the addendum as effectively deleting the provision providing for deduction of costs.

The CDA as amended and interpreted by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA (which provides for consideration totaling $1,795.20) is approved. An attorney fee of $448.80, payable from this consideration 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
BRETT D. WILSON, Claimant
WCB Case No. 96-03297
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's back injury claim; and (2) awarded an assessed attorney fee of $16,000. In his respondent's brief, claimant contends that the ALJ's attorney fee award should be increased. On review, the issues are compensability and attorney fees.

We adopt and affirm the ALJ's order, as supplemented below.

First, we change the references in the ALJ's "Findings of Fact" from "1996" and "1997" in the second paragraph to, respectively, "1976" and "1977." We also change the ALJ's references throughout the order from "Dr. Garner" to "Dr. Gardner."

Furthermore, with regard to the ALJ's compensability analysis, as SAIF notes, the ALJ did not discuss the opinion from claimant's current treating physician, Dr. Niles. Although Dr. Niles initially reported that the work injury was the major contributing cause of the need for treatment of the current condition (Ex. 57), in a subsequent deposition, she indicated that she did not know whether the work injury or preexisting condition was the major contributing cause (Ex. 58-16). Because Dr. Niles neither supported nor disputed a causal relationship between the work injury and current condition, we find that her opinion has little impact on the compensability issue.

We do not adopt the last paragraph of the ALJ's attorney fee award discussion. In response to SAIF's and claimant's attorney's arguments concerning the ALJ's award of $16,000, we first note that there is no dispute regarding claimant's counsel's statement that he devoted 70.7 hours to the case.[1] Moreover, with regard to other factors under OAR 438-015-0010(4),[2] we also agree that the case involved more complex issues and had a more complex procedural history than the average case because of the "post-denial" IME question. The value of the interest involved and the benefit secured for claimant were substantial because claimant required surgery. Based on the competing medical opinions, there was a risk that claimant's attorney could go uncompensated.

Because of the substantial time, legal complexity, and value of the case, we disagree with SAIF that claimant's attorney fee should be limited to approximately $10,000. But we also do not agree with claimant's counsel that the factors in this case are so exceptional that a reasonable fee is his requested amount of approximately $21,000. Rather, we agree with the ALJ that, based on the factors in this case, especially the time devoted to the case, the complexity of the issues and procedural history, and the value interest involved, a reasonable attorney fee is $16,000.

Claimant's attorney also is entitled to an assessed fee for services on review concerning compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted

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[1] The procedural history of this case is more complex than the average because a hearing was held in 1996 and, on review, the Board vacated and remanded for consideration of a "post-denial IME" -- a matter that is no longer disputed. The order now on review is on remand from the Board.

[2] 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. 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 the case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the ALJ's attorney fee award. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 30, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

September 28, 1999 Cite as 51 Van Natta 1546 (1999)

In the Matter of the Compensation of
EDWIN HUENI, JR., Claimant
WCB Case No. C991744
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Popick & Merkel, Claimant Attorneys
Zimmerman & Nielsen, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

On July 16, 1999 the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we disapprove the proposed disposition.

On July 23, 1999, the Board wrote the parties noting that the CDA provided that no consideration would be paid to claimant, but, rather, that claimant's consideration was an offset of an overpayment. Because an overpayment cannot qualify as CDA "proceeds," the CDA as drafted was without consideration. Consequently, the Board was unable to approve the CDA. *See Karen L. Begeal*, 49 Van Natta 231 (1997); *Timothy W. Moore*, 44 Van Natta 2060 (1992). In light of the deficiency in the CDA, an addendum to the CDA was requested.

On September 20, 1999, we received a letter from claimant's counsel withdrawing the CDA. However, because more than 30 days has passed since submission of the CDA for approval, we are unable to disapprove the agreement under ORS 656.236(1)(a)(C).

Nevertheless, pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if a deficiency noted in an addendum letter is not corrected within 21 days. To date, the parties have not submitted the addendum as requested in our July 23, 1999 letter. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. OAR 438-009-0020(4)(b).

If the parties wish to resubmit a revised CDA (consistent with the matters discussed in our July 23, 1999 letter) at a later date, they may do so. If and when such an agreement is received, we will proceed with our review of that particular CDA.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD T. SWENSON, Claimant
WCB Case No. 98-08576
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that found that claimant was not permanently and totally disabled. On review, the issue is permanent total 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 left shoulder and back strains and ruptured disc at C3-4 as a result of a March 1995 injury. A May 1998 Notice of Closure awarded unscheduled permanent disability; that award was increased by the Order on Reconsideration.

The ALJ found that claimant did not prove permanent total disability based either on medical factors or the "odd lot" doctrine. Claimant challenges those conclusions, asserting that the persuasive medical evidence carried his burden of proof under either theory.

In May 1997, claimant underwent surgery for a fusion at C3-4. When claimant continued to have pain in his neck and right arm six months later, claimant's treating surgeon, Dr. Zelaya, noted that claimant had "developed a chronic pain syndrome associated with muscle spasms, for which there does not seem to be a clear treatment." (Ex. 215).

In February 1998, Dr. Zelaya reported to the claims examiner that, based on the post-surgery studies, "there is evidence of a good fusion at the level of C3-4" but a CT showed spinal stenosis at C3. (Ex. 263-1). Dr. Zelaya further reported that he "would consider [claimant] disabled from this lesion" and that the spinal stenosis was "aggravated when he looks up or down and the level of pain increases." (*Id.* at 2). Finally, Dr. Zelaya noted that claimant should be in "a close and controlled environment so he does not abuse his medications." (*Id.*)

In March 1998, Dr. Zelaya found that claimant was "stable at a low level, mainly because of his chronic pain syndrome" and that he was "unable to work, even in a sedentary type of job, because that would involve movement of his neck and increased tension in the neck muscles and he is unable to do that." (Ex. 275).

In April 1998, claimant underwent an examination by Dr. Gripekoven, orthopedic surgeon, and Dr. Zivin, neurologist. The panel found a degenerative disc at the C3-4 level. (Ex. 278-6). The panel further found a significant psychological component, along with functional interference. (*Id.* at 6, 7). In discussing claimant's work restrictions, the panel reported that claimant could "pursue more sedentary type of occupation in a sheltered environment" but that such restrictions "are in large part, related to the preexisting conditions in his cervical and lumbar spine as the major contributing cause for the need of these modifications." (*Id.* at 8).

Dr. Zelaya first concurred with the panel's report. (Ex. 281). Dr. Zelaya subsequently explained, however, that he did not concur with the "Comments and Recommendations" in the report. (Ex. 293-1). According to Dr. Zelaya, claimant had to change position every 15 minutes or less; was unable to twist and bend his neck; developed headaches if he did not change position; had worse pain whenever reaching overhead; and had back and shoulder pain from previous surgeries. (*Id.*) Based on this condition, Dr. Zelaya reported that claimant "chances for gainful employment" were "very poor." (*Id.*)

Dr. Zelaya further explained that claimant had "significant stenosis" and a "bony spur at the level of C3-4, which intermittently compresses the spinal cord, and the symptoms he has are consistent with intermittent compression of the spinal cord." (*Id.*) Dr. Zelaya thought that if claimant returned to even sedentary or light work, "he will be in danger of hurting himself." (*Id.*)

Dr. Zelaya subsequently concurred with the medical case manager's letter stating that Dr. Zelaya "agreed" that claimant "was not totally disabled." (Ex. 304-2). Specifically, the letter found that, although claimant "may continue to have pain complaints and some physical limitations, his objective findings indicate he has maintained a reasonable level of strength and physical functioning to allow him to continue a sedentary level of work at home and in a work situation." (*Id.*)

Finally, the medical arbiter, Dr. Tiley, found that claimant exhibited "marked excessive pain behavior" and that the range of motion findings were "invalid since casual observation at other times during the interview and examination show greater ranges of motion are accomplished[.]" (Ex. 338-3). Furthermore, Dr. Tiley found that claimant's accepted conditions had resolved and "do not play a role in [claimant's] impairment at the present time." (*Id.* at 5-6). Like the examining panel, Dr. Tiley also found "significant psychological problems some of, [sic] which may be drug induced." (*Id.* at 6). According to Dr. Tiley, claimant's "residual functional capacity is dependent on factors that are not physical in nature" and there was "nothing from a physical perspective that would prevent this man from doing full occupational activities[.]" (*Id.* at 9).

"Permanent total disability" is "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). In determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. *See Nyre v. F & R Leasing*, 106 Or App 74 (1991). Subsequent, noncompensable conditions are not considered. *Elder v. Rosboro Lumber Co.*, 106 Or App 16 (1991).

Here, we agree with the ALJ that claimant failed to prove that he is permanently and totally disabled based on medical factors alone. First, although Dr. Zelaya in some reports found that claimant was "totally disabled," his last opinion showed that he considered claimant capable of sedentary activity.

Furthermore, there is a lack of evidence showing that claimant is totally disabled from his accepted conditions of shoulder and back strains and ruptured disc at C3-4. In discussing claimant's disability, Dr. Zelaya referred to other conditions, including spinal stenosis and a bony spur, and found that claimant's symptoms were consistent with such conditions. Dr. Tiley thought that the accepted conditions had resolved and were not contributing to any impairment. The record also contained evidence of contribution from significant psychological problems, as well as substance abuse.

Claimant also asserts that he proved permanent and total disability under the "odd lot" doctrine. Under this theory, a disabled person with some residual physical capacity may still be permanently and totally disabled due to a combination of his physical condition and nonmedical factors such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the condition of the labor market. *Clark v. Boise Cascade Co.*, 72 Or App 397 (1985).

The only evidence supporting this assertion is a report from Barbara Kronsteiner, vocational consultant. Her report states that a "Job Order Wage Report" for a particular period "was reviewed for appropriate occupations in the sedentary category of work" and "[n]o occupations in this category were identified." (Ex. 308-3).

The employer provided evidence from a rehabilitation counselor, Kathryn Whitcombe. This report found that claimant was "employable in a variety of occupations" and identified several physically appropriate occupations. (Ex. 323-16). The report also indicated that such work "exists in reasonable numbers" and provided employer contact information verifying that prior work experience was not necessary. (*Id.*)

Ms. Whitcombe's report showed that it was based on review of medical and vocational materials, vocational resource materials from the Department of Labor, and contact with employers.[1] In contrast, Ms. Kronsteiner's was conclusory and did nothing to explain her review of vocational materials or provide employer contact information. For this reason, we are more persuaded by the report from Ms. Whitcombe finding that suitable employment is available to claimant. Thus, we also agree with the ALJ that claimant did not prove permanent and total disability based on the "odd lot" doctrine.

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[1] We disagree with claimant that the Whitcombe report should be discounted because it included employer contacts located only within the Portland metropolitan area and claimant resides in the southern coastal area. Although some contacts included those in Portland, the report also shows that there were employer contacts in Gold Beach, Eugene, and Coos Bay.

ORDER

The ALJ's order dated April 11, 1999 is affirmed.

September 29, 1999 Cite as 51 Van Natta 1549 (1999)

In the Matter of the Compensation of
ELAMUEL C. BARKER, Claimant
Own Motion No. 99-0292M
OWN MOTION ORDER
Kryger, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted a request for temporary disability compensation for claimant's compensable left shoulder condition. Claimant's aggravation rights expired on June 13, 1995. The insurer agrees that claimant's current condition is causally related to his accepted condition and that it is responsible for claimant's current condition. However, the insurer initially contended that it was unknown whether claimant was in the work force at the time of the current disability.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

In response to our August 6, 1999 letter requesting work force information, claimant submitted a copy of his Work/Education History form showing that he has continued working, at least part-time, through August 2, 1999.[1] The insurer responded to claimant's submission and agreed that "this [claimant] remained in the work force at the time of the worsening of his compensable condition requiring surgery." In light of claimant's submission and the insurer's concurrence, 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 August 4, 1999, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

[1] 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, 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 August 4, 1999, when claimant underwent the recommended surgery. *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).

In the Matter of the Compensation of
ORVEL L. CHANEY, Claimant
Own Motion No. 99-0250M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On July 20, 1999, we withdrew our July 16, 1999 Own Motion Order, which denied claimant's request for own motion relief on the ground that he was not in the work force at the time of his current worsening. We took this action to consider claimant's submission of an affidavit in support of his contention that he was in the work force. Having considered the SAIF Corporation's response and the parties' respective positions, we republish our prior order (as supplemented below).

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

It is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). 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 he was willing to work. Failing to demonstrate his 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).

On reconsideration, claimant submitted an affidavit stating that he is "always willing to work, but it is impossible * * * my left knee is defective." Claimant further asserted that, because further surgery was required, he was unable to work due to his compensable condition. Based on claimant's assertions, we are persuaded that claimant is willing to work.

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. The record lacks medical evidence supporting claimant's contention that he was unable to work due to his compensable condition. The record does not establish that claimant was taken off work due to his compensable injury and/or that it would have been futile for him to seek work. Accordingly, we are neither persuaded that claimant was unable to work at the time of his 1999 worsening nor that it would have been futile for him to seek work due to the compensable condition.

Accordingly, our July 16, 1999 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 16, 1999 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY L. BESHEONE, Claimant
WCB Case No. 98-08458
ORDER ON REVIEW
Whitehead & Klosterman, 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) Myzak's order that set aside its denial of claimant's claim for a left ankle injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has filed prior workers' compensation claims, including a thumb injury claim with this employer in August 1998. (Tr. 13; 14; 18 through 21).

Claimant was working for the employer operating a track hoe on the Corrine Heights project near Portland, Oregon, on Thursday, September 17, 1998. At about three or three-thirty that afternoon, Mr. Jackson, project superintendent, came to the jobsite and told claimant that the project had been shut down, effectively laying claimant off. Jackson directed claimant to contact the employer to see if there was any other work available. (Tr. 16, 54, 55, 56). Claimant filled out his time card for that day, indicating that he worked ten hours. He did not indicate on the form that he was injured on the job. (Ex. 1; Tr. 15). At 5:23 p.m., claimant made a brief telephone call to the employer's office. (Ex. A-2).

On Friday, September 18, 1998, claimant left a message for Warren Jones, co-owner of the business, asking where to report for work on Monday. (Exs. A-3, 4A). Claimant visited family in Medford from Monday, September 21, 1998 through Monday, September 28, 1998. Claimant took his cell phone with him; the employer had his cell phone number. During the same period, through the morning of September 29, 1998, claimant left a series of messages for Jones; Rick Mathews, superintendent; and Larry, the other co-owner; asking that they return his calls. (Exs. 4B, 4C, 5A).

On the afternoon of September 29, 1998, claimant sought medical treatment for a left ankle sprain that allegedly took place at work on September 17, 1998 at about 2:00 p.m. (Ex. 6). Claimant was diagnosed with a left ankle sprain, provided with an air splint and crutches, and released to modified work with restrictions from lifting, prolonged standing and walking, climbing ladders or stairs, work above shoulder level, and driving. (Exs. 6, 7, 8) Claimant's physician filed a Form 827 with SAIF. (Ex. 6).

SAIF's claims adjuster called the employer on or about October 9, 1998, which was the first knowledge the employer had of the claim. (Tr. 12; Ex. 12A-5; 14).

CONCLUSIONS OF LAW AND OPINION

The ALJ found *all* witnesses to be credible, but confused as to dates, and concluded that claimant had established a compensable left ankle injury. On review, SAIF continues to contest claimant's credibility and, based on inconsistencies in the record and testimony at hearing, asserts that claimant failed to prove compensability. We agree.

To establish a compensable injury, claimant has the burden to prove that he sustained an accidental injury arising out of and in the course of employment. ORS 656.266; 656.005(7)(a).

In evaluating the reliability of claimant's testimony, we first note that, because the ALJ relied on the "preponderance of evidence," her credibility findings were not based only on demeanor. Although we generally defer to the ALJ's credibility findings, when the issue of credibility concerns the substance of a witness's testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987).

Here, claimant contends that he twisted his left ankle at work on September 17, 1998, at about 2:00 or 2:30 pm. But claimant did not seek treatment for the alleged injury until September 29, 1998, eleven days later.

Meanwhile, about an hour after the alleged incident, Mr. Jackson, project superintendent, arrived at the job site to tell claimant that he would not be needed any more because the project had been shut down. Jackson directed claimant to contact the main office regarding further work. Claimant did not mention the alleged injury to Jackson or to the two other workers on the jobsite, nor did he indicate that he had been injured that day on the timecard for September 17, 1998. (Tr. 10, 55, 56; Ex. 12a-2). Moreover, he did not mention the alleged injury or any work limitations to the receptionist when he called the main office a number of times over the eleven-day period between the date he allegedly sprained his ankle and September 29, 1998, the date he sought treatment. Rather, the record shows that claimant left messages trying to find out where he was to report to work and that he wanted to go back to work, even as a bidder. (Exs. A-2, -3; 4A; 12a-2; Tr. 25, 26, 27, 28, 38, 43).

Although claimant averred that, if Warren (Jones) or Larry or Rick (Meadows) had called him back, he would have told them that he was injured but could perform light duty, the record of claimant's requests for work do not weigh in favor of a finding that claimant had been injured and was trying to report the injury. Rather, a more reasonable interpretation is that claimant, who had been laid off of the project he had been working on, simply wanted to get back to some kind of work. This interpretation is strengthened by the testimonies of Jones and Meadows that they had spoken with claimant sometime during the period prior to his seeking medical treatment and had told him that they had no work, either in claimant's prior capacity as a foreman or even as a bidder. In sum, this evidence merely shows that claimant was anxious to get back to work after the project shutdown. It does not support claimant's claim that he had been injured, was trying to report the injury and was trying to obtain light duty work.

Other facts also weigh against claimant's credibility. First, claimant was familiar with the claims process and had filed a prior thumb claim with the employer after being instructed by the employer to do so. Thus, there is nothing in the employer's prior course of conduct to support claimant's reasoning that he was doing the employer a favor by not immediately filing a claim.

Second, after claimant sought treatment and made the claim for the alleged injury, he told SAIF's claims examiner that he had left many messages with the employer requesting a claim form. But when confronted by the claims examiner, who said: "[W]hen I talked to [the employer] they said that they never knew that you were saying that you had an injury," claimant changed his story, stating: "That's cause no one, I wasn't talking to anybody. I'd call and no one would be there." (Ex. 12a-4).

When we assess the record as a whole (including claimant's failure to report the injury to the employer coupled with his failure to seek treatment until eleven days later, as well as his conflicting stories to SAIF's claims examiner regarding the content of the messages he left at work), we conclude that claimant has failed to prove that he sustained an accidental injury arising out of and in the course of employment.

ORDER

The ALJ's order dated April 30, 1999 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

September 28, 1999 Cite as 51 Van Natta 1552 (1999)

In the Matter of the Compensation of
RONALD D. REYNOLDS, Claimant
WCB Case No. 98-04171
ORDER OF DISMISSAL (REMANDING)
Malagon, Moore, et al, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

The SAIF Corporation requested review of Administrative Law Judge (ALJ) Myzak's order that: (1) directed SAIF to recalculate claimant's temporary total disability rate; (2) awarded claimant temporary disability; (3) assessed SAIF a penalty for allegedly unreasonable claim processing; and (4) awarded an insurer-paid and "out-of-compensation" attorney fees. The parties have submitted a proposed stipulation for our consideration.

Pursuant to the stipulation, the parties agree that the ALJ's order should be vacated and this matter remanded to the ALJ for the consideration of "additional evidence and amendments to the Order which would clarify and correct some issues in the original Order." The stipulation further provides that the ALJ has agreed to reconsider her order, which "would resolve some [of] the disagreements with the Order as it now stands."

By this order, we have approved the parties' stipulation. In granting this approval, we find that the uncontested representations contained in the agreement establish that this case has been incompletely and insufficiently developed. Consequently, we conclude that remand is warranted to allow the ALJ an opportunity to consider the admission of additional evidence and correction of her order which would assist the parties in resolving some of their disagreements. *See* ORS 656.295(5).

Accordingly, the ALJ's orders dated August 10, 1999 and August 13, 1999 are vacated. This matter is remanded to ALJ Myzak for further action consistent with the parties' stipulation and this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALFONSO CARRANZA-ROMERO, Claimant
WCB Case No. 97-05388
ORDER ON REMAND
Bruce D. Smith, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Carranza-Romero*, 161 Or App 658 (1999). The court has reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order awarding claimant temporary total disability benefits from July 3, 1996 through November 27, 1996 and an "out of compensation" attorney fee. Like the ALJ, we concluded that claimant's "substantive" entitlement to temporary benefits at claim closure was not contingent on a contemporaneous authorization of time loss from an attending physician. Citing *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999), the court has remanded for reconsideration.

In *Bundy*, the court reversed our decision *Kenneth P. Bundy*, 48 Van Natta 250 (1996), that held that the 14 day limitation on "retroactive" temporary disability authorization from an attending physician set forth in ORS 656.262(4)(g) was not applicable to "substantive" temporary disability awarded at the time of claim closure. After reviewing the legislative history of ORS 656.262(4), the court concluded that the statute's reference to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days, regardless of whether the claim was open or pending closure.

ORS 656.262(4)(g) provides that temporary disability 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.*" (Emphasis added). The statute further provides that no temporary disability authorization under ORS 656.268 "shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance." As noted above, in *Bundy*, the court held that this section applies to the substantive entitlement to benefits at claim closure as well as the procedural obligation to pay temporary disability while the claim is open.

Here, the record contains no contemporaneous temporary disability authorization from an attending physician for the time period in issue, July 3, 1996 through November 27, 1996 (the date claimant was declared permanently and totally disabled). Claimant had been treating with Dr. Svihus at Sutter-Yuba Mental Health in Yuba City, California. But in June 1996, Dr. Svihus advised the SAIF Corporation that he did not wish to be claimant's attending physician and that he did not agree to accept Oregon's workers' compensation rules. When claimant did not secure a new attending physician and provide documentation of his continued inability to work, SAIF terminated his temporary disability benefits as of July 3, 1996.

Because the record does not contain a time loss authorization from an attending physician for the period in dispute, claimant is not entitled to temporary disability benefits between July 3, 1996 and November 27, 1996.[1]

Accordingly, on reconsideration, the ALJ's October 27, 1997 order is reversed.[2] The June 27, 1997 Order on Reconsideration is reinstated and affirmed.

IT IS SO ORDERED.

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[1] Even if Dr. Svihus had agreed to be, and could be considered as, claimant's attending physician under the Oregon administrative rules, the record contains no contemporaneous documentation from Dr. Svihus verifying claimant's inability to work during the period in question.

[2] Because claimant's award of temporary disability has ultimately been reduced, we also rescind the $288 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

In the Matter of the Compensation of
DIANA L. HANSEN, Claimant
WCB Case Nos. 99-03518 & 98-08637
ORDER OF DISMISSAL
Hollander & Lebenbaum, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

The SAIF Corporation has requested review of Administrative Law Judge (ALJ) Hazelett's July 2, 1999 order. Liberty Northwest Insurance Corporation has filed a motion to dismiss SAIF's request for Board review, contending that SAIF neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order. *See* ORS 656.289(3); 656.295(2). Because the record does not establish that all parties received timely notice of SAIF's request, we dismiss.

FINDINGS OF FACT

On June 16, 1999, ALJ Hazelett conducted a hearing that involved claimant, Liberty Northwest and its insured, and SAIF and its insured. On July 2, 1999, ALJ Hazelett issued an Opinion and Order that set aside SAIF's denial of claimant's L5-S1 condition. The order also upheld Liberty's denial of the same condition. Copies of that order were mailed to claimant, claimant's attorney, SAIF, SAIF's attorney and SAIF's insured. Copies were also mailed to Liberty, Liberty's attorney, and Liberty's insured.

On July 30, 1999, the Board received SAIF's July 29, 1999 request for Board review of the ALJ's order. SAIF's request provided that copies had been mailed to claimant, her attorney and SAIF's insured. There was no indication that copies had been mailed to Liberty, its counsel, or its insured.

On August 2, 1999, the Board mailed its computer-generated letter to all parties and their attorneys acknowledging its receipt of SAIF's request for Board review. Liberty did not receive a copy of SAIF's request for review until August 18, 1999, when it contacted the Board asking for a copy.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Argonaut Insurance Co.*, 63 Or App at 852.

Here, the 30th day after the ALJ's July 2, 1999 order was August 1, 1999. The Board received SAIF's request for review on July 30, 1999. Inasmuch as the request was received by a permanent office of the Board prior to expiration of the aforementioned 30-day statutory period, it was timely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that all parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of SAIF's request for review within the statutory 30-day period. Specifically, Liberty's (and its insured's) first notice occurred on August 18, 1999 when Liberty received a copy of the request from the Board.[1] Because August 18, 1999 is more than 30 days after the ALJ's July 2, 1999 Opinion and Order, such notice is untimely *Debra A. Hergert*, 48 Van Natta 1052 (1996); *John E. Bafford*, 48 Van Natta 513 (1996).

Under such circumstances, we conclude that notice of SAIF's request was not provided to all parties within 30 days after the ALJ's July 2, 1999 order. Therefore, we lack jurisdiction to review the ALJ's order.[2] *See* ORS 656.289(3); 656.295(2).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] We note that the Board's acknowledgment letter regarding this matter did not issue until August 2, 1999, which was the last day of the appeal period. Consequently, it would not have been possible for Liberty to have received notice by way of the acknowledgment letter prior to the expiration of the 30-day period.

[2] On review, SAIF attempted to limit its appeal to the issues of its compensability denial and attorney fees. SAIF also requested that Liberty be "dismissed" as a party, based on its contention that responsibility was not an issue on review. Notwithstanding SAIF's position, we conclude that Liberty was a "party" to the ALJ's order and therefore, because of its status as a party, SAIF was required to provide Liberty with timely notice of the request for review. In reaching this conclusion, we rely on the reasoning set forth in *Mosley*, which provided that a request for Board review is a request of the *ALJ's order*. *Mosley v. Sacred Heart Hospital*, 113 Or App at 237. Consequently, SAIF may not limit its request for review to particular issues or case numbers addressed by the ALJ's order.

In the Matter of the Compensation of
FEDERICO MARIN, Claimant
WCB Case No. 98-07990
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
William J. Blitz, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that awarded interim compensation from September 3, 1998 through September 26, 1998. On review, the issue is temporary disability.

We adopt and affirm the ALJ's order with the following modification of the ALJ's factual findings. The sixth sentence of the first paragraph of the "Findings of Fact" should begin with "On or about August 13, 1998," not "On January 6, 1995."[1]

Because claimant's compensation has not been disallowed or reduced as a result of the employer's request for review, 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

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[1] In support of its argument, the employer refers to Exhibit 11 on page 2 of its reply brief. However, that exhibit was withdrawn and not admitted into evidence. (Tr. 1).

services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 11, 1999 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

In the Matter of the Compensation of
LESLIE D. HARTSOUGH, Claimant
WCB Case No. 98-08896
ORDER ON REVIEW (REMANDING)
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that dismissed his request for hearing. On review, the issue is the propriety of the ALJ's dismissal order. We reverse and remand.

FINDINGS OF FACT

Claimant was compensably injured on February 17, 1996. The claim was accepted as a nondisabling claim for a left sacroiliac strain and then closed on May 30, 1996.

After her claim was closed, claimant continued to seek treatment for her low back condition. On September 10, 1998, Dr. Johnson reported that he was not sure that claimant's symptoms were the result of her injury in February 1996, but he could not "disprove it either."

On September 24, 1998, the claims administrator wrote to claimant on behalf of the employer, stating that:

> "We have medical bills for treatment after closure of your claim on May 30, 1996. Our work-up to date indicates your ongoing low back problems after our closure of May 30, 1996, did not arise out of or in the course and scope of your employment with the City of Ashland. It is also our position your accepted left sacroiliac strain of February 17, 1996, has not materially worsened. Accordingly, we must deny your claim for workers' compensation benefits. This is a denial of legal and medical causation."

On November 9, 1998, claimant requested a hearing and raised the issues of compensability and aggravation.

On February 4, 1999, Dr. Thomas reported that claimant's current condition was related to the compensable injury. Dr. Thomas recommended injection therapy.

On February 10, 1999, Dr. Woodward reviewed claimant's records on behalf of the employer. Dr. Woodward reported that he did not believe it was reasonable to relate claimant's current symptoms to the February 1996 injury.

On February 22, 1999, the employer wrote to the ALJ to confirm that it was amending the September 24, 1998 denial and rescinding the portion of the denial that purported to deny an aggravation claim, as "such denial is premature in light of the fact that claimant has now informed that no such claim for aggravation has yet been perfected."

On April 15, 1999, the employer wrote to the ALJ and argued that, because the aggravation denial had been rescinded, the only remaining issue was medical services. Consequently, the employer requested dismissal of claimant's request for hearing.

On May 18, 1999, claimant responded to the employer's motion to dismiss and contended that the remainder of the amended denial had not been rescinded and the Hearings Division had jurisdiction over the matter.

On May 19, 1999, the ALJ issued an Order of Dismissal that found that the sole issue was medical services and the Hearings Division lacked jurisdiction.

CONCLUSIONS OF LAW AND OPINION

In dismissing claimant's request for hearing, the ALJ concluded that the remaining issue was one of medical services. Therefore, relying on the Court's decision in *SAIF v. Shipley*, 326 Or 557 (1998), the ALJ reasoned that the Hearings Division did not have jurisdiction over claimant's request for hearing.

In *Shipley*, the Court held that the Board lacked jurisdiction to address the compensability of a claim that was solely for medical services. However, subsequent to the decision in *Shipley*, we have held that where a denial constitutes a denial of a claimant's current condition as well as a denial of medical services, we retain jurisdiction. *David L. Dylan*, 50 Van Natta 852 (1998). In *Dylan*, the employer's denial provided that: "We do have a claim for medical services but the medical records indicate that neither your work activity at [the employer] nor your prior April 27, 1990 injury is the major contributing cause of your current need for treatment or disability." The Board concluded that, because the denial constituted a denial of the claimant's current condition as well as a denial of medical services, jurisdiction remained with the Board rather than the Director. *Id.*

Here, as claimant contends, following the employer's rescission of its aggravation denial, the denial continues to provide that claimant's current condition did not arise out of or in the course and scope of employment and therefore, based on both legal and medical causation, the claim was denied. Under the circumstances, we conclude that the issue in this case is not solely an issue of compensability of medical services.[1] Therefore, the ALJ had jurisdiction over the merits of the compensability of claimant's current condition. *See, e.g., Marie Ostin*, 50 Van Natta 2201 (1998) (ALJ properly dismissed the claimant's request for hearing regarding unpaid medical bills but upheld the employer's partial denial of the claimant's current condition).

We have declined to remand in cases in which there was a hearing and the parties agreed that the issue of compensability was at issue and they were prepared to proceed on that issue. *See, e.g., Robert C. Gray*, 49 Van Natta 1953 (1997). However, in the present case, no hearing was held and no written argument was submitted with respect to the issue of compensability. Accordingly, we conclude that the record is incompletely developed and this matter should be remanded to the ALJ. ORS 656.295(5). Therefore, we remand to ALJ Brown for further proceedings consistent with this order to be conducted in any manner that the ALJ determines will achieve substantial justice to all the parties.

ORDER

The ALJ's order dated May 19, 1999 is vacated. Claimant's hearing request is reinstated. The matter is remanded to ALJ Stephen Brown for further proceedings consistent with this order.

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[1] We note that, effective October 23, 1999, in accordance with legislative amendments to ORS 656.704(3), the Board has jurisdiction over all "causality-based" disputes-(other than MCO disputes arising under ORS 656.260) which includes disputes pertaining to the compensability of a condition and disputes involving whether treatment is related to an accepted claim. 1999 Or Laws, Ch. 926, section 2.

In the Matter of the Compensation of
JAMES K. HOLDERMAN, Claimant
WCB Case No. 99-00691
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Livesley's order that affirmed the Order on Reconsideration that increased claimant's 21 percent (10.08 degrees) scheduled permanent disability award for loss of use or function of the right thumb to include awards for loss of opposition for claimant's fingers. 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 following change. In the first sentence on page 2, we change the date to "September 23, 1998."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his right thumb while operating a table saw. (Ex. 1). His right thumb tip had been "partially avulsed just at the very end of the distal pad." (Ex. 1B). No bony injury was detected. (*Id.*) SAIF accepted a disabling claim for "laceration to the tip of right thumb." (Ex. 4).

On September 23, 1998, Dr. Wilson reported that claimant was medically stationary. (Ex. 2). Claimant's right thumb showed a 10 percent distal tip amputation impairment, and the nail was intact. (*Id.*) There was a 10 mm sensory loss over the palmar surface of the thumb, from the IP joint distally. (*Id.*)

On October 13, 1998, a Notice of Closure awarded 21 percent scheduled permanent disability for loss of use or function of the right thumb. (Ex. 5). The award included 10 percent for amputation of the distal tip of the thumb and 12 percent for loss of sensation. (Ex. 5-2).

Claimant requested reconsideration on the basis that his award should be adjusted to reflect his loss of opposition. (Ex. 6). The December 31, 1998 Order on Reconsideration increased claimant's scheduled permanent disability award to include 10 percent for loss of opposition for the right index finger, 10 percent for loss of opposition for the right middle finger and 5 percent for loss of opposition for the right ring finger. (Ex. 7-3). The Order on Reconsideration explained the increased award as follows:

> "**Loss of Opposition in Thumb Amputation**: See OAR 436-035-0040(1)(a): For amputation[s] which are not exactly at the joints, adjust the rating in steps of 5% increasing as the amputation gets closer to the attachment to the hand, decreasing to zero as it gets closer to the tip. OAR 436-035-0040(2)(a): For thumb amputations at the interphalangeal level:
>
> Index finger - 10%
> Middle finger - 10%
> Ring finger - 5 %
> Little finger - 0%" (Ex. 7-2) (emphasis in original).

SAIF requested a hearing concerning the Order on Reconsideration. The ALJ affirmed, reasoning in part as follows:

> "The evaluator utilizing OAR 436-035-0040(2)(a) found that claimant had suffered a loss of opposition to the index finger of 10%. Since that section deals with amputations at the interphalangeal joint and grants a 20% loss of opposition therefore, the inference is that the evaluator made a 5% adjustment covering the area from the proximal end of the distal phalanx, and an additional 5% adjustment for the distal end of the distal phalanx to reach the flesh above the distal phalanx. I can find no error in that analysis." (O & O at 2).

On review, SAIF argues that the ALJ erred in concluding that claimant was entitled to awards for loss of opposition because of the amputation of the tip of his thumb. For the following reasons, we agree.

OAR 436-035-0040 (WCD Admin. Order No. 98-055) provides for awards related to loss of opposition in thumb amputations. Loss of opposition is rated as a proportionate loss of use of the uninjured digits that can no longer be effectively opposed. OAR 436-035-0040(1). For amputations that are not exactly at the joints, the ratings are adjusted in steps of 5 percent, increasing as the amputation gets closer to the attachment to the hand and decreasing to zero as it gets closer to the tip. OAR 436-035-0040(1)(a). When the value for loss of opposition is less than 5 percent, no value is granted. OAR 436-035-0040(1)(b).

Here, claimant's right thumb tip was partially avulsed at the "very end" of the distal pad. (Ex. 1B). No bony injury was detected. (*Id.*) At the time of claimant's closing examination, his right thumb showed a 10 percent distal tip amputation impairment, and the nail was intact. (Ex. 2). Dr. Wilson reported that claimant "has full movement of the thumb without any difficulties." (*Id.*) The medical records did not refer to any problems with loss of opposition of any of claimant's fingers. *Compare Terrance L. Moore*, 49 Van Natta 1787 (1997) (physician reported that the claimant had difficulty opposing the thumb to the base of the fifth finger). Our findings must be based on medical evidence in the record. *See SAIF v. Calder*, 157 Or App 224 (1998) (Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge; rather, the findings must be based on medical evidence). On this record, we find no evidence to support the conclusion that claimant has a loss of opposition related to the compensable injury. Consequently, we conclude that claimant is not entitled to a scheduled permanent disability for loss of opposition.

ORDER

The ALJ's order dated May 17, 1999 is reversed. In lieu of the December 31, 1998 Order on Reconsideration, the October 13, 1998 Notice of Closure (which awarded claimant 21 percent (10.08 degrees) scheduled permanent disability for the right thumb) is reinstated and affirmed. The ALJ's attorney fee award is reversed.

September 30, 1999 Cite as 51 Van Natta 1559 (1999)

In the Matter of the Compensation of
DON A. LARSEN, Claimant
WCB Case No. 98-07004
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the insurer's denial of claimant's injury claim for a right L4-5 disc herniation; (2) upheld the insurer's denial of claimant's current left L4-5 disc condition; and (3) declined to award a penalty for allegedly unreasonable claims processing. On review, the issues are compensability, claims processing, and penalties.

We adopt and affirm the ALJ's opinion on the compensability issues and substitute the following with regard to the penalty issue.

In light of our conclusion that claimant's right L4-5 disc and left L4-5 discs are not compensable, 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 April 23, 1999 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's analysis for the following reasons. The ALJ concluded that Dr. Young's report was more persuasive than that of Dr. Gallo. But Dr. Young's report was incomplete, as he either overlooked or omitted any comment on the presence of the disc fragment found and removed by the surgeon in 1989. Moreover, Dr. Young did not address the 1989 clinical diagnosis of an acutely herniated right lumbar disk after the immediate onset of progressively severe pain with no prior history of medical treatment for any kind of back pain.

Dr. Gallo, on the other hand, explained that, as a consequence of the 1989 surgery, claimant suffered weakened spinal tissue, including scar tissue and fibrosis, was the result of the surgery, rather than the combination of the original injury and any degenerative changes. Thus, I would find that, based on the medical record that shows the effects of the 1989 surgery--a compensable medical treatment for claimant's compensable low back injury--led directly to the herniated disc requiring surgery in 1998. Accordingly, I would conclude that, as the consequence of compensable medical care, the 1998 disc herniation and surgery is a compensable claim that Liberty cannot deny as a matter of law. *See Barrett Business Services v. Hames*, 130 Or App 190 196-96, *rev den* 320 Or 492 (1994) (the distinction between the compensable injury and its treatment is artificial).

Accordingly, I would set aside the denial of the 1989 disc herniation and find that that condition was accepted as a part of the original injury claim and award a penalty on the amounts due. Moreover, I would find the 1998 L4-5 herniation and disc surgery to be a compensable consequence of the 1989 disc surgery and would assess penalties for Liberty's failure to process the claim. For these reasons, I respectfully dissent.

September 30, 1999 Cite as 51 Van Natta 1560 (1999)

In the Matter of the Compensation of
KAREN M. STONE, Claimant
WCB Case No. 99-00640
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Bruce Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's claim for a C5-6 disc bulge; and (2) awarded a $3,500 assessed attorney fee pursuant to 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 regarding the attorney fee issue.

We disagree with the ALJ's mathematical application of a 50 percent "multiplier."[1] However, for the reasons set forth above, we nonetheless find that the ALJ's award of a $3,500 attorney fee is reasonable considering the factors in 438-015-0010(4).

In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

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[1] The risk in a particular case that an attorney's efforts may go uncompensated is one factor to be considered in determining a reasonable attorney fee under OAR 438-015-0010(4). We do not, however, apply a contingency factor or "multiplier" in a strict mathematical sense. *June E. Bronson*, 51 Van Natta 928, 931 n 5 (1999).

Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

The disputed issue at hearing was the compensability of claimant's C5-6 disc bulge. Claimant's attorney spent 15.5 hours on the case at the hearing level. The record contains 71 exhibits. The transcript is 19 pages long. Claimant was the only witness. There were no depositions. The case involved issues of average medical and legal complexity, as compared with compensability issues generally presented to the Board's Hearings Division for resolution. The value of the claim and the benefits secured are above average to the extent that the cervical condition may require surgery. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions, there was a risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $3,500 is a reasonable attorney fee for services at the hearings level in this case. In reaching this conclusion, we have particularly considered the time devoted to the case, the value of the interest involved and the risk that claimant's counsel might go uncompensated. Accordingly, we affirm the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services devoted to the attorney fee issue on review. *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated May 10, 1999 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
LEONARD R. TERRIBLE, Claimant
WCB Case No. 97-04381
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Claimant requests reconsideration of our August 6, 1999 order that set aside the self-insured employer's denial of claimant's occupational disease claim for a stress-related mental disorder and awarded an assessed fee of $6,500 for the hearing and Board levels. *Leonard R. Terrible*, 51 Van Natta 1375 (1999). Claimant seeks an increase in our attorney fee award at the hearing level to $26,250.

On August 31, 1999, we withdrew our August 6, 1999 order to consider claimant's motion. Having received the employer's response to claimant's motion, we proceed with our reconsideration.

In determining a reasonable attorney fee for claimant's counsel's services at the hearings level, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). 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 an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

In response to claimant's counsel's request for a $26,250 attorney fee, the employer argues that, although the hearing required 3 days of testimony, the witnesses' testimony was brief and focused. The employer also argues that Dr. Noparstak's deposition was only lengthy because the doctor improperly refused to provide legible summaries of his handwritten chart notes and that time spent by claimant's counsel at the deposition should therefore not be compensated. The employer also argues that the issue was not complex and involved a dispute between medical experts. Finally, the employer disagrees with claimant's argument that he stands to receive significant benefits. In this regard, the employer asserts that there is no indication in the record that claimant suffers permanent disability. The employer also argues that any temporary disability benefits will be limited because claimant received full pay from the employer until his voluntary resignation and his physician did not authorize temporary disability until many months after claimant's employment ended.

Claimant agrees that the witnesses' testimony was brief and focused, but argues that the hearing nonetheless required three days. Claimant disagrees with the employer's argument that the issue was not complex. In addition, claimant argues that he will receive significant temporary disability benefits and will be entitled to receive medical treatment.

Having considered the arguments, we turn to an application of the factors to the circumstances of this case. The disputed issue at hearing was the compensability of claimant's occupational disease claim for a mental disorder. Claimant's attorney does not keep specific records of time spent on cases and based on a review of the file estimated the amount of time spent on the case at 75 hours. The record contains approximately 30 exhibits, including a lengthy (150 page) deposition of claimant's treating psychiatrist. The hearing lasted approximately three days and the transcript was approximately 420 pages long. Seventeen witnesses testified. On Board review, claimant submitted a twelve page appellant's brief and a twelve page reply brief. The case involved issues of above average medical and legal complexity, as compared with compensability issues generally presented to the Board for resolution.[1] As a result of the denial being overturned, claimant will receive medical treatment and will likely receive temporary disability benefits. In addition, there is a possibility of a permanent disability award. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions and the employer's statutory and other vigorously litigated defenses, there was a significant risk that claimant's counsel's efforts might have gone uncompensated.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $26,250 is a reasonable attorney fee for services at hearing and on Board review. We reach this conclusion because of the significant amount of time devoted to the issue, the extensive nature of proceedings, the benefit obtained, the risk that claimant's counsel might go uncompensated and the value of the interest to claimant.

On reconsideration, as modified herein, we republish our August 6, 1999 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

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[1] For example, the employer raised a constitutional defense to claimant's claim.

WORKERS' COMPENSATION CASES

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Cite as 161 Or App 262 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

BEV SLEIGH, Respondent,
v.
JENNY CRAIG WEIGHT LOSS CENTRES, INC., and KIMBERLY STUBBLEFIELD-TAKLA, Appellants.
(9507-04638; CA A95213)

Appeal from Circuit Court, Multnomah County.
William C. Snouffer, Judge.
Argued and submitted December 14, 1998.
Gerald J. Huffman argued the cause for appellants. With him on the briefs were David Whitaker, Sue Ann Kelly, and Lemle & Kelleher, LLP., and Timothy R. Volpert, Lori Lee Brocker, and Davis Wright Tremaine, LLP.
Elizabeth McKanna argued the cause for respondent. With her on the brief were Ralph E. Wiser, and Bennett Hartman Reynolds & Wiser.
Before Landau, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
DEITS, C. J.
Reversed and remanded.

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161 Or App 264> Plaintiff brought this action under ORS 659.121, alleging that defendants, her employer and one of its supervisory employees, discriminated against her by disciplining and discharging her because of a work-related injury and concomitant use of the workers' compensation system and because of her age. ORS 659.410; ORS 659.030. The trial court entered judgment pursuant to the jury's verdict for plaintiff on both claims, and defendants appeal.[1] We reverse.

Plaintiff was hired in 1989, when she was 57 years old. She sustained a compensable injury in January 1993. Between the time of her return to work later that year and September, when defendants discharged plaintiff, she was disciplined or subjected to other negative personnel measures several times, was the object of one or more customer complaints, and was warned that she would be terminated if her performance and behavior did not improve. She had experienced few, if any, disciplinary problems before her injury. At trial, the key factual issue was whether plaintiff's conduct warranted the post-injury disciplinary measures and was the reason for the discharge, or, conversely, whether plaintiff's purported misconduct and the resulting discipline were fabricated or exaggerated by defendants as part of the same discrimination that plaintiff alleges also motivated defendants to fire her.

After the discharge, plaintiff filed unlawful employment practices complaints with the state Bureau of Labor and Industries (BOLI). With regard to plaintiff's allegations of discrimination based on her injured employee status, BOLI's investigator produced a five-page "notice of administrative determination." *See* ORS 659.050. The notice was based in large measure on interviews with customers and coworkers. It contains a number of specific "findings" that challenge the validity or the appropriateness of defendants' disciplinary actions and ascribes them to the employer's **<161 Or App 264/265>** desire "to rid itself of an injured worker." The notice concludes with the "determination" that BOLI "finds substantial evidence of [unlawful employment practices] based on injured worker status in violation of ORS 659.410." However, in a separate report, the BOLI investigator reached the opposite conclusion as to whether there was substantial evidence of discrimination based on age. Plaintiff then brought this action, and the administrative proceedings before BOLI did not advance from the investigative stage to a contested case proceeding under ORS 659.060. *See* ORS 659.095.

Through a pre-trial motion *in limine* and, again, at trial, defendants objected to the admission of the BOLI determination notice, offered by plaintiff, relating to the claimed discrimination based on her injured worker status. Defendants asserted that the evidence was hearsay and that its potential for prejudice outweighed its probative value under OEC 403. The trial court overruled the objection,

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[1] Plaintiff also asserted a claim for intentional infliction of emotional distress. The jury found for defendants on that claim, and no issue concerning it is presented on appeal.

rejecting the OEC 403 contention and concluding that the notice came within the exception to the hearsay rule contained in OEC 803(8)(c).[2] That section makes admissible in civil actions the reports, records, statements or compilations of data of public offices or agencies that set forth

> "factual findings, resulting from an investigation made pursuant to authority granted by law, unless the sources of information or other circumstances indicate lack of trustworthiness."

In their first two assignments, defendants contend that the trial court erred by admitting the adverse BOLI notice, and they repeat both of the grounds for its exclusion that they advanced in the trial court. We agree with defendants that the evidence does not come within OEC 803(8)(c) and that it is therefore inadmissible hearsay.

Our review of the text and context of the rule, and particularly of the term "factual findings," does not resolve all doubt about its meaning as relevant to the matter in question. Accordingly, we turn to the legislative history. The Supreme Court has incisively concluded that "the Legislative **<161 Or App 264/265>** Commentary on the Oregon Evidence Code should be considered as part of that Code's legislative history." *State ex rel OHSU v. Haas*, 325 Or 492, 506 n 10, 942 P2d 261 (1997). The Legislative Commentary to OEC 803(8)(c) states, in part:

> "The Legislative Assembly intends that this paragraph not provide a sweeping exception for public records containing evaluations or opinions. 'Factual findings' is to be strictly construed to allow as evidence only those reports, otherwise in accord with the rule, which are based on firsthand observation by the public official making the report. *See, e.g., Finchcum v. Lyons*, 247 Or 255, 428 P2d [890] (1967) (admitting findings of pathologist that potatoes were infected with ring rot because evidence did not suggest that investigation involved exercise of discretion); *Davis v. Georgia Pacific*, 251 Or 239, 445 P2d 481 (1968) (admitting results of investigation by State Sanitary Authority on amount of fallout from mill because statements in documents were fact and not opinion). Where there are still factors present that cast doubt upon the trustworthiness of a record, this subsection authorizes the trial judge to exclude it."

Quoted in Laird C. Kirkpatrick, *Oregon Evidence*, 565 (2d ed, 1989).

In his text, Kirkpatrick states that the applicability of OEC 803(8)(c) "depend[s] on the extent to which the finding was one of fact rather than opinion, and the extent to which the finding was based on [the investigator's] personal knowledge rather than hearsay information." *Id.* at 573. That test corresponds roughly to the one that the Oregon Supreme Court followed in connection with the predecessors of OEC 803(8)(c), which it summarized as requiring "that the officer making the entry *either* have had personal knowledge of the facts or that he had a duty of ascertaining the truth of such facts." *Wynn v. Sundquist*, 259 Or 125, 134, 485 P2d 1085 (1971) (emphasis in original).

The evidence here does not pass the test for admissibility under OEC 803(8)(c). It is based on hearsay rather than the investigator's firsthand knowledge; it arrives at opinions of the investigator rather than setting forth purely factual matters; and the ultimate opinion at which it **<161 Or App 266/267>** arrives--that there is substantial evidence of discrimination--was not, and was not designed to be, a determination of the truth of a fact, but was merely a preliminary conclusion that sufficient grounds existed for the continuation of an administrative process that, had it been followed to its conclusion, would eventually culminate in a determination about the truth of the fact. The evidence does not come within the exception, and its admission was error.[3]

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[2] Defendants later introduced and the trial court admitted the BOLI determination that there was not substantial evidence of age discrimination.

[3] Neither *Oberg v. Honda Motor Co.*, 316 Or 263, 269, 851 P2d 1084 (1993), *rev'd on other grounds*, 512 US 418, 114 S Ct 2331, 129 L Ed 2d 3361 (1994), nor *McCuller v. Gaudry*, 59 Or App 13, 650 P2d 148 (1982), is to the contrary. In *Oberg*, the Supreme Court concluded that, unlike here, the evidence in question was not hearsay, because it was not offered for the truth of the matter asserted. In *McCuller*, the objection to the evidence was not based on hearsay grounds, nor was our opinion.

Our disposition makes it unnecessary for us to reach defendants' argument based on OEC 403.

Plaintiff argues that the error in admitting the evidence is harmless--or at least not reversible--because the court gave a curative instruction to the effect that the jurors should base their findings on their own evaluation of the evidence and that "BOLI's findings in this matter are not binding upon you. * * * A finding of substantial evidence is not equal to a finding that a company or individual is guilty of discrimination." Plaintiff also argues that there was "substantial evidence," independent of the BOLI determination, sufficient to support the verdict. We do not agree that the error is harmless for either reason. The other evidence could have readily supported a finding either way on the question of discrimination based on plaintiff's injured worker status, and the finding could have turned largely on competing inferences that the jurors could draw from the evidence. Moreover, the BOLI determination was "strong" in its support of plaintiff. There is a substantial likelihood that the inadmissible evidence could have affected the verdict. Similarly, the curative instruction was inadequate to diffuse the prejudice. Indeed, it effectively apprised the jurors that they *could* give some weight to the inadmissible evidence. It cured nothing.

Finally, plaintiff argues that defendant's subsequent introduction into evidence "of the BOLI finding regarding age discrimination offset any adverse impact of the [injured **<161 Or App 267/268>** worker] finding and precludes a claim of error by defendants on appeal." Insofar as plaintiff's points in this connection attempt to further her demonstration that the weight of the evidence rendered the error harmless, we reject them for the reasons stated above.

However, citing *State v. Brown*, 299 Or 143, 699 P2d 1122 (1985), plaintiff also contends that, as a general proposition, "[w]here a party objects to the introduction of evidence by an opponent but then later offers the same evidence for an independent reason, the objecting party cannot claim error on appeal." In *Brown*, the court held that the trial court's error in admitting evidence of the criminal defendant's probationary status was harmless because, in his own later testimony, the defendant mentioned his probationary status for an "independent reason." 299 Or at 152. The situation here differs, in that defendants did not offer the *same* evidence as the evidence to which they objected; they offered evidence that was of the same general *kind* but that differed in substance and pertained to a different fact and to a different claim. If the intended premise of plaintiff's point is a variation of the "invited error" rationale, we disagree with the premise. Defendants offered the BOLI age discrimination determination *after* the court had made it clear through the ruling on plaintiff's evidence that it considered the BOLI reports to be admissible. No principle of which we are aware or that plaintiff identifies precludes defendants from asserting the error under these circumstances. The trial court erred by admitting the BOLI determination concerning the injured worker discrimination claim, and the error is reversible.

Of defendants' remaining assignments, we consider one to be sufficiently likely to arise on remand to require its discussion here. Defendants contend that the trial court erred by refusing to give their requested instruction:

> "An employer has broad discretion to retain or dismiss its employees. The issue before you is not whether you agree with [the employer's] judgment, but whether its decision was made for lawful reasons."

The substance of what defendants sought to impart to the jury through the proposed instruction was adequately communicated through other instructions, including others that **<161 Or App 268/269>** defendants successfully requested. Moreover, the form of the proposed instruction is argumentative. On this record, the refusal to give it was not error.

Reversed and remanded.

Cite as 161 Or App 290 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

KAIB'S ROVING R.Ph. AGENCY, INC., Petitioner,
v.
EMPLOYMENT DEPARTMENT, Respondent.
(96-T-0123A; CA A96552)

Judicial review from Employment Appeals Board.

Argued and submitted on January 19, 1999.

Harvey J. Shulman, *pro hac vice*, Washington, D. C., argued the cause for petitioner. With him on the briefs were Craig A. Etter and Ginsburg, Feldman and Bress, Chartered.

Mary H. Williams, Assistant Solicitor General, argued the cause for respondent. With her on the brief was Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.

Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.

EDMONDS, P. J.

Reversed and remanded for reconsideration.

*Deits, C. J., *vice* Warren, P. J., retired.

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161 Or App 292> Kaib's Roving R.Ph. Agency, Inc. (Kaib's) seeks judicial review of a final decision by the Employment Department upholding an assessment against it for employment taxes in 1993, 1994 and 1995. We conclude that the Employment Department erred in its application of ORS 670.600 and remand. ORS 183.482(8)(a).

Since 1987, Kaib's has provided licensed pharmacists to Oregon pharmacies in need of temporary relief services. Pharmacists interested in filling temporary vacancies are matched by Kaib's with pharmacies seeking such services. Kaib's has been audited by two state agencies, the Department of Revenue and the Employment Department, to determine whether its pharmacists are properly classified under ORS 670.600 as independent contractors. A Department of Revenue conference officer determined that the pharmacists were independent contractors during 1991. Subsequently, the Employment Department determined that, during 1993 through 1995, the pharmacists were not independent contractors. At issue in this case is the relationship of 54 pharmacists to Kaib's during 1993 through 1995. Some, but not all, of those pharmacists worked through Kaib's in 1991 and were subjects of the Department of Revenue's determination. If the subject pharmacists are employees of Kaib's, then it is liable for the assessments; if they are independent contractors, then Kaib's is relieved of that responsibility.

The parties present two questions on appeal that bear on that issue: (1) Did the Employment Department err in determining that Kaib's failed to establish that the pharmacists named in the tax assessment were independent contractors under the criteria set forth in ORS 670.600; and (2) did the Employment Department err in concluding that it was not required to give any weight to and was not bound under the doctrine of issue preclusion by the Department of Revenue's determination that the pharmacists working for Kaib's in 1991 were independent contractors under ORS 670.600? Because the answer to the second question affects what evidence the Department was required to consider in determining whether the pharmacists were employees or **<161 Or App 292/293>** independent contracts in 1993 through 1995, we address it first.

In an affidavit dated October 1996, the president of Kaib's stated that "Kaib's has not made any material changes in its operations between 1991 and the present." Three witnesses, who worked for Kaib's in 1991 and in later years, testified that there had been no change in their work relationship or arrangement. Kaib's argues that:

> "the overwhelming and uncontroverted testimony--including the testimony from the Employment Department's own witnesses--was that there had been no change in Kaib's relationship with the pharmacists. [Citing to the testimony of the three witnesses]. To conclude that there were differences in the treatment of the workers in a later year, the Employment Department must do more than just say this case involves different years."

The Employment Department ruled that it could completely disregard the evidence of the Revenue Department's determination:

> "* * * The appellant contends that since the issue in the Revenue Department proceeding is identical to the issue in this proceeding, and the issue was actually litigated by Revenue and was essential to a final decision on the merits, the Employment Department must adhere to the results of the Revenue proceeding.
>
> "However, the matter before the Department of Revenue conference officer was neither litigated nor the subject of a final decision. The Revenue Department issued a letter following an informal conference with the appellant. The Revenue Department's action did not represent an administrative adjudication and final decision as contemplated by the Oregon Administrative Procedure Act. See ORS 183.413 through 183.480. Even assuming that Revenue's informal process precluded a different result in another forum, the conference letter itself specifically limits the applicability of Revenue's findings to calendar year 1991.
>
> "Nevertheless, the appellant argues that the conference letter should be applied to all future years. The Department of Revenue, however, limited its applicability for very good reasons. No agency, particularly one charged with levying and collecting taxes, would make such a ruling applicable to **<161 Or App 293/294>** the indefinite future. Obviously things change. Revenue's conference letter, to the extent it could possibly be construed as preclusive, could not, by any stretch of the imagination, be applied to circumstances that arise after the specific dates to which the letter applies. The appellant has cited no statute or appellate court opinion in support of such an application, and the administrative law judge has found none."

ORS 670.600 (1993) provided, in part:[1]

> "As used in various provisions of ORS chapters 316 [the revenue code], 656 [workers' compensation law], 657 [unemployment law], and 701 [laws governing construction contractors], an individual or business entity that performs labor or services for remuneration shall be considered to perform the labor or services as an 'independent contractor' if the standards of this section are met[.]"

In *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d 1 (1994), the court was faced with the issue of how the statutory definition of "independent contractor" in ORS 670.600 affects statutory provisions for determining when a person is subject to Oregon workers' compensation law in ORS chapter 656. The court examined the legislative history underlying the statute and concluded,

> "[the] legislative history strongly suggests that the primary purpose of [ORS 670.600] was to achieve uniformity in who qualifies as an independent contractor, so that one who is an independent contractor for purposes of one of the four laws cited above would also be an independent contractor for purposes of the other three laws." 318 Or at 628.[2]

161 Or App 295> Specifically at issue in *S-W Floor Cover Shop* was whether the phrase "direction and control" in ORS 670.600(1) was a different "actual control" test from the judicially created "right to control" test that historically had been applied in conjunction with ORS 656.005(28). After quoting from the legislative history, the court ruled:

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[1] ORS 670.600 remained unamended after its enactment in 1989 and during the tax years at issue in this case until it was amended by 1997 Oregon Laws, chapter 398, section 2, to encompass ORS chapters 448, laws governing the construction of swimming, water and sewer facilities, and 671, laws governing architects and landscape contractors. *See* Or Laws 1989, ch 762, section 1.

[2] The opinion refers to committee testimony in which it was noted:

> "As an example, since the Employment Division laws and our laws are not the same, on many occasions, employers have not provided workers' compensation coverage because the worker was not subject to unemployment tax. With [ORS 670.600], if one of the other agencies determines noncompliance in this area, we should be able to issue our own order of noncompliance without conducting another investigation." 318 Or at 627.

> "Those excerpts, as well as a great deal of discussion in committee not reproduced in this opinion, make it clear that the committee considered at length the 'direction and control' issue and intended the case law interpreting that phrase as used in ORS 656.005(28) to apply to that phrase as used in the independent contractor definition found in ORS 670.600." 318 Or at 630.

The court concluded that the same "direction and control" test appears in both ORS 656.005(28) and ORS 670.600.

The holding in *S-W Floor Cover Shop* is instructive in the analysis of whether the Employment Department was required to give weight to or is precluded by the Department of Revenue's determination that the pharmacists working for Kaib's were independent contractors. It is clear from the court's holding that the legislature, when enacting ORS 670.600, intended that there be uniformity and consistency among the enumerated agencies when determining independent contractor status. When the Supreme Court interprets a statute, that interpretation becomes a part of the statute as if it had been included in the statute at the time of its enactment. *Gaston v. Parsons*, 318 Or 247, 252, 864 P2d 1319 (1994). Because the court interpreted ORS 670.600 in *S-W Cover Floor Shop* as intending that an individual who qualifies as an independent contractor for purposes of one of the statutory schemes cited would also be an independent contractor for the purposes of the other cited statutory schemes, the Department of Revenue's determination in this case is necessarily implicated.

We examine first Kaib's argument that the doctrine of issue preclusion prevents the Employment Department from making a finding different than that of the Department of Revenue. The general doctrine of issue preclusion can be applied to administrative proceedings. *See North Clackamas School Dist. v. White*, 305 Or 48, 52, 750 P2d 485, *on recons* **<161 Or App 295/296>** 305 Or 468, 752 P2d 1210 (1988). Five requirements must be met:

> "1. The issue in the two proceedings is identical.
>
> "2. The issue was actually litigated and was essential to a final decision on the merits in the prior proceeding.
>
> "3. The party sought to be precluded has had a full and fair opportunity to be heard on that issue.
>
> "4. The party sought to be precluded was a party or was in privity with a party to the prior proceeding.
>
> "5. The prior proceeding was the type of proceeding to which this court will give preclusive effect." *Nelson v. Emerald People's Utility Dist.*, 318 Or 99, 104, 862 P2d 1293 (1993) (citations omitted).

Here, the Employment Department points out that the years at issue and the employees are not entirely identical and asserts that the matter before the Department of Revenue was not litigated nor the subject of a final decision. Also, the Employment Department correctly reasoned that work relationships by their nature may change over time and that, because circumstances may differ from year to year, issue preclusion would not necessarily operate to bind agencies to past determinations made under ORS 670.600 for different tax periods. However, it is also conceivable that, as Kaib's avers, there were no material changes in its relationships with its pharmacists between 1991 and the years in question.

There is nothing in the language of ORS 670.600 that incorporates the doctrine of issue preclusion as the exclusive means of determining whether consistency has been afforded by the subject agencies' determinations. The legislature's directive to agencies to afford consistency in their determinations is broader than just the doctrine of issue preclusion. Even if the doctrine of issue preclusion does not apply, the legislature has indicated its intention that there be uniformity and consistency in holdings among agencies when applying ORS 670.600 to the same employer. It would be contrary to the legislature's intent if the Employment Department could wholly disregard the Department of Revenue's findings and assert its independence from the ruling without **<161 Or App 296/297>** assessing whether its proposed decision would be inconsistent with the Department of Revenue's prior decision.

The Employment Department appears to recognize that aspect of ORS 670.600 when it discusses the application of the Department of Revenue's determination to future years for purposes of tax assessment. However, it then assumes that the ruling has no binding effect on future years without evaluating *whether changes did in fact occur.* We do not understand the record in this case to reveal that the kind of factual consideration that the statute contemplates occurred.

Moreover, the Employment Department recognizes the principles of statutory preclusion and statutory presumption, *see, e.g.*,ORS 43.130, ORS 43.140, and OEC 311, but argues that "ORS 670.600 does not create a statutory preclusion that would require the Employment Department to be bound by the Department of Revenue ruling." The statute may not require that one agency to be *bound* by another agency's determination concerning a different year, but agencies are required to act consistently by the statute unless there are material factual distinctions or procedural irregularities that would justify an inconsistency. The Employment Department's argument that it should have latitude to make its own interpretation and application of ORS 670.600 within the context of its statutory mandate apart from considering another agency's determination involving the same employer does not comport with the primary purpose of ORS 670.600 and 670.605[3] to achieve uniformity. *S-W Floor Cover Shop*, 318 Or at 628.

Also, the Employment Department appears to argue that the Supreme Court concluded in *S-W Floor Cover Shop* that the definition of independent contractor in ORS 670.600 could be applied differently, based on other statutory provisions that govern a particular agency. To the contrary, the court's conclusion was that the threshold determination under ORS 656.005(28) of whether an individual is a **<161 Or App 297/298>** "worker" governs whether workers' compensation insurance premiums must be paid. *Id.* at 622. Therefore the court reasoned that in a workers' compensation case, the issue of who is a "worker" may make it *unnecessary* to reach the issue of whether the individual is an "independent contractor" under ORS 670.600. *Id.* at 630-31. Those concerns are not present in this case, and nothing in *S-W Floor Cover Shop* can be understood to allow agencies to avoid the mandate that determinations under ORS 670.600 be uniform and consistent.

In summary, we interpret ORS 670.600 to require the Employment Department to consider the Department of Revenue's earlier determination and determine whether its later proposed decision is consistent or inconsistent. If it determines that its decision is inconsistent, then it must provide a reasoned explanation why, under ORS 670.600, it is permitted to reach a different determination. That explanation may be that factual distinctions actually require a different result, or that there was an irregularity in the procedure before the Department of Revenue that is material to the Employment Department's determination of the facts in this case, or that there is some other explanation that is consistent with the legislature's intent regarding ORS 670.600. What cannot suffice as a matter of law under ORS 670.600 is the explanation that the Employment Department will not consider itself bound by the Department of Revenue's determination merely because that determination involved a different year or because the Department is entitled to make its own determination independent of any effect of another listed agency's determination. Such reasoning runs counter to the legislature's intention that agencies and employers are entitled to rely on consistent treatment by the enumerated agencies in conducting their business affairs.

Because the Employment Department must reconsider the evidence offered by Kaib's regarding the Department of Revenue's prior determination, we are unable to reach the first question presented by the parties.

Reversed and remanded for reconsideration.

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[3] ORS 670.605 provides:

"In accordance with ORS 183.310 to 183.550, those agencies responsible for the administration of ORS chapters 316, 656, 657 and 701, *jointly* shall adopt rules to carry out the provisions of ORS 670.600." (Emphasis added.)

Cite as 161 Or App 367 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael D. Cessnun, Claimant.

SAIF CORPORATION and GARY FOGLIO TRUCKING, INC., Petitioners,
v.
MICHAEL D. CESSNUN, Respondent.
(97-09918; CA A103416)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 29, 1999.
David L. Runner argued the cause and filed the brief for petitioners.
Christopher D. Moore argued the cause for respondent. With him on the brief was Malagon, Moore & Jensen.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Reversed and remanded for reconsideration.

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161 Or App 369> Employer seeks review of the order of the Workers' Compensation Board (Board) that held claimant's occupational disease claim compensable. Employer contends that the Board applied the wrong legal standard when it concluded that claimant did not have a "preexisting condition" within the meaning of ORS 656.005(24). We reverse and remand for reconsideration.

We review the Board's order to determine whether, as a matter of law, the Board applied an incorrect legal standard. ORS 183.482(8)(a); *Fred Meyer, Inc. v. Crompton*, 150 Or App 531, 533, 946 P2d 1171 (1997). In its order, the Board adopted the administrative law judge's (ALJ) findings of fact, and we derive the following facts from those findings.

Claimant began working as a log truck driver for employer in 1989. His work required frequent and often forceful overhead use of his arms as he threw and tightened chain and cable binders over the logs on his truck. In 1996, his left shoulder began to bother him. By April 1997, the shoulder had become painful when he was engaged in overhead activity or lifting. On July 16, 1997, he sought medical treatment, and subsequently a large rotator cuff tear was found. Claimant filed his workers' compensation claim on September 8, 1997. In November, claimant's treating physician performed surgery to repair the rotator cuff tear. During surgery, he noted the presence of a prominent acromial spur, which he later stated was a "preexisting condition" that was a "causative factor" in the development of claimant's rotator cuff tear.[1] The physician identified claimant's work as the major contributing cause of both the pathological worsening of the rotator cuff tear and the need for treatment. According to the treating physician, the rotator cuff tear was not the result of any specific acute injury. Instead, the tear began "insidiously" and became worse over time as claimant repeatedly used his arm in overhead work.

161 Or App 370> Employer denied the claim for compensation. Following a hearing, the ALJ concluded that claimant's work activity had combined with a preexisting condition, but that the claim was compensable because claimant's work activity was the major contributing cause of the combined condition, of the pathological worsening of the preexisting condition, and of the need for treatment of the combined condition. On review, the Board affirmed, but based its decision on a different analysis. The Board concluded that it first was required to decide whether claimant had a preexisting disease or condition within the meaning of ORS 656.005(24). In determining that he did not, the Board appears to have decided, as a matter of law, that, at least in occupational disease cases, a disease or condition is not "preexisting" unless it is present before the start of the work exposure that eventually leads to the

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[1] The "acromion" is "the outer end of the spine of the scapula" and "form[s] the outer angle of the shoulder * * * articulating with the clavicle." *Webster's Third New Int'l Dictionary*, 19 (unabridged ed 1993).

claim. The Board found that claimant did not have such a disease or condition in this case, because there was no evidence that the acromial spur in his left shoulder was present before he began working for employer in 1989. Having found that claimant's occupational disease claim was not based on a worsening of a separate preexisting disease or condition, the Board then considered whether claimant's work for employer was the major contributing cause of his left rotator cuff tear. Deferring to the opinion of claimant's treating physician, the Board decided that it was and agreed with the ALJ that the claim was compensable.

On review, employer argues that the Board erred when it concluded that, in an occupational disease case, a "preexisting condition" must predate the work exposure that eventually leads to the claim. Employer contends that a "preexisting" condition must antedate

> "that point in time at which the alleged occupational disease has become manifest, has required medical treatment or resulted in disability, and has been claimed by the claimant under the Workers' Compensation Law or has otherwise come to the employer's attention as a work-related condition."

Claimant agrees with the Board's legal analysis and also argues, alternatively, that, even under employer's reading of the statutes, his claim is compensable. We agree with **<161 Or App 370/371>** employer that the Board erred, but we do not accept its statutory analysis. We conclude that, in occupational disease cases, a disease or condition is a "preexisting" one only if it both "contributes or predisposes [the claimant] to disability or a need for treatment," ORS 656.005(24), *and* precedes either the date of disability or the date when medical treatment is first sought, whichever occurs first. Because the Board applied an incorrect legal standard, we remand for reconsideration.

We begin our analysis by setting out the pertinent statutory provisions. The Board found, and the parties appear to accept, that this case involves an occupational disease claim. We agree, because claimant's rotator cuff tear developed gradually, rather than as the result of a discrete event. *See Mathel v. Josephine County*, 319 Or 235, 240, 875 P2d 455 (1994) (classic distinction between occupational diseases and injuries is that occupational diseases are "gradual rather than sudden in onset"). An "occupational disease" is statutorily defined as:

> "[A]ny disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, *and which requires medical services or results in disability or death* * * *."

ORS 656.802(1)(a) (emphasis added).

Under the occupational disease law, a claimant "must prove that employment conditions were the major contributing cause of the disease." ORS 656.802(2)(a). In addition:

> "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)(b) (emphasis added). An occupational disease claim generally is "considered an injury." ORS 656.804. In particular, "[o]ccupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries **<161 Or App 371/372>** under ORS 656.005(7)." ORS 656.802(2)(c). *See also Brown v. A-Dec, Inc.*, 154 Or App 244, 247, 961 P2d 280 (1998) (applying the provisions of ORS 656.005(7)(a)(B) "in determining the compensability of an occupational disease").

A "compensable injury" is:

> "[A]n accidental injury * * * arising out of and in the course of employment *requiring medical services or resulting in disability or death* * * *."

ORS 656.005(7)(a) (emphasis added). Among the "limitations and exclusions" that apply to accidental injury claims--and that therefore also apply to occupational disease claims pursuant to ORS 656.802(2)(c)--is the following provision:

> "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) (emphasis added). A "preexisting condition" is defined 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*, or that precedes a claim for worsening pursuant to ORS 656.273."

ORS 656.005(24) (emphasis added).

At issue in this case is whether claimant's claim is subject to the specific causation requirements of ORS 656.802(2)(a) and ORS 656.005(7)(a)(B), which turns on whether he had a "preexisting condition" within the meaning of the relevant statutes. The Board held, and claimant agrees, that claimant's condition was not "preexisting" within the meaning of the statutes, because it did not precede the commencement of his 1989 employment. Employer argues that claimant's condition was "preexisting," because it preceded the claim itself. In resolving that question, we **<161 Or App 372/373>** attempt to ascertain the intended meaning of the statutes, looking to their text in context and, if necessary, their legislative history and other interpretive aids. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993).

ORS 656.005(24), the statute which defines "preexisting condition," draws a distinction between an "initial" claim and one "for worsening pursuant to ORS 656.273"--in other words, an aggravation claim. *See* ORS 656.273(2) ("To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer."); ORS 656.245(4)(b)(A) (permitting insurers or self-insured employers to require injured workers to receive services from managed care organizations "[f]or initial or aggravation claims" filed after a certain date); ORS 656.262(15) (allowing suspension of all or part of compensation if worker unreasonably fails to cooperate with investigation regarding "an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition"). In the case of an "initial" claim, such as this one, to be "preexisting," a disease or condition--or at least one that is distinct from the allegedly compensable disease or condition--must have "precede[d] the onset" of the claim. ORS 656.005(24). In the case of an aggravation claim, a "preexisting condition" is one that precedes the claim itself. Thus, the statute draws a distinction between preceding the "onset" of the claim and preceding the claim itself. The two are not synonymous.[2]

In that light, employer's construction of the statutes is untenable. Employer reads "the onset of the * * * claim" as the filing of the claim itself. That deprives the phrase "the onset of" of any meaning and ignores the distinction between "the onset of the * * * claim" and the claim itself, which is reflected in the language of ORS 656.005(24).

It remains to be determined, however, precisely what "onset" means. In common usage, the term refers to **<161 Or App 373/374>** "beginning, commencement, start." *Webster's Third New Int'l Dictionary*, 1577 (unabridged ed 1993). A "claim" is statutorily defined as either "a written request for compensation from a subject worker * * * or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). It is apparent that the "onset" of a "claim" does not refer to the commencement of the written request for compensation and that the relevant definitional component is the onset of the "compensable injury." In the case of an occupational disease, however, there is frequently no discrete injurious event that may be identified. The hallmark of an occupational disease is its gradual development. *Mathel*, 319 Or at 240.

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[2] Our holding does not affect the extent to which, in cases involving the last injurious exposure rule, a claimant may rely on the entirety of his or her prior employment in proving that an occupational disease was caused by employment-related exposure.

For that reason, the "onset" of an occupational disease generally has been regarded as the point at which the disease manifests itself. *See generally 3 Larson's Workers' Compensation Law* section 39.50 (1988). Our decisions are consistent with that general approach. In *Medford Corp. v. Smith*, 110 Or App 486, 488, 823 P2d 441 (1992), for example, we held that, in the absence of a discrete disability, "the date of the onset of the [occupational] disease is the date on which claimant first sought medical treatment." Similarly, in *Papen v. Willamina Lumber Co.*, 123 Or App 249, 254, 859 P2d 1166 (1993), we held that "[t]he date of injury in an occupational disease case is either the date of disability or the date when medical treatment is first sought." Nothing in the text or context of the relevant statutes suggests that the legislature intended to depart from that understanding as to the meaning of "onset" of an occupational disease.

In that light, the Board's construction is likewise untenable. Its conclusion that "the onset of the claim" refers to the commencement of employment finds no support in the language of the statute and cannot be reconciled with prior case law holding that the "onset" of an occupational disease is either the date the disability becomes manifest or the date of first medical treatment.

The Board followed its interpretation with a citation to our decision in *The New Portland Meadows v. Dieringer*, 153 Or App 383, 957 P2d 190 (1998). We find nothing in that decision that lends support to the Board's interpretation, **<161 Or App 374/375>** however. In that case, the claimant had worked for two employers, first in Washington and then in Oregon. She filed an occupational disease claim based on work conditions in both employment locations. The employer argued that the causation standard for combined conditions applied, because the claimant had a preexisting condition--her employment in Washington--and that, as a result, she should be required to prove that her Oregon employment was the major contributing cause of her disability or her need for treatment. The Board held that, because the claimant had filed a claim for a single condition based on her employment in both locations, there was no preexisting condition. We agreed, holding that a portion of a compensable condition cannot be its own "preexisting condition." *Id.* at 387-88. We did not hold that a "preexisting condition" dates from the commencement of employment.

Claimant argues that, if the Board applied an incorrect legal analysis, a remand is not necessary because the medical evidence still is sufficient to prove that this claim is compensable. Ultimately, the Board may agree or disagree, but "[t]hat is for the Board to decide in the first instance on remand." *Medford Corp.*, 110 Or App at 489. We therefore remand to the Board for it to reconsider this case under the correct legal standard.

Reversed and remanded for reconsideration.

Cite as 161 Or App 516 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jon B. Strubel, Claimant.

SAIF CORPORATION and INTERSTATE DISTRIBUTOR CO., Petitioners,
v.
JON B. STRUBEL, Respondent.
(97-03693; CA A101471)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 15, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
David W. Hittle argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
ARMSTRONG, J.
Affirmed.

*Kistler, J., *vice* Warren, P.J., retired.

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161 Or App 518> SAIF seeks review of a decision by the Workers' Compensation Board that set aside SAIF's denial of claimant's claim. SAIF contends that the Board failed to apply the proper statutory test for a combined condition and, therefore, that the Board erred as a matter of law. We conclude that the Board applied the proper test and that the Board's conclusion is supported by substantial evidence. Accordingly, we affirm the Board's decision.

The administrative law judge (ALJ) found the following facts, which were adopted by the Board. Claimant, along with his wife, is a long-haul truck driver. They work as a team, delivering freight to various locations in the western United States from their base in Woodburn, Oregon. Claimant and his wife load and unload the freight, which is packed in totes that weigh up to 70 pounds. In early December 1996, claimant and his wife made three freight runs to stores in Arizona, California, and Utah. They made 31 deliveries in nine days, driving seven to eight thousand miles and loading and unloading many tons of freight. On December 18, 1996, they made a freight run to the Los Angeles area, during which they unloaded 30,000 pounds of freight in six hours.

On the return trip to Oregon, claimant's wife drove the first leg while claimant slept in the sleeper area of the cab. In the early morning hours of December 19, 1996, claimant's wife woke claimant so that he could drive. At that time, claimant noted that he had symptoms of pain and neck stiffness that worsened as he drove. Although claimant's neck pain gradually improved, the stiffness and pain radiated to his left shoulder and arm, where they persisted to the point that claimant sought medical attention. Among other doctors, claimant was examined by Dr. Thorsett, an orthopedic surgeon; Dr. Hubbard, a neurologist; Dr. Gardner, a neurologist; and Dr. Huff, an orthopedic surgeon. Gardner and Huff examined claimant as part of an independent medical evaluation (IME) requested by SAIF. Thorsett and Hubbard were claimant's treating physicians.

Claimant's condition was diagnosed as left C-6 radiculopathy and as a left C-6 soft disc herniation. Gardner and **<161 Or App 518/519>** Huff classified claimant's condition as a combined condition caused by underlying degenerative disc disease and work activity, but they attributed the major cause of the combined condition to the natural progression of the underlying degenerative disc disease. Although Thorsett initially concurred with the IME report--in a "check the box" form sent to him by SAIF--he later submitted a report to claimant's attorney in which he stated that the most likely major contributing cause of claimant's symptoms was a lifting injury associated with claimant's work as a truck driver. The ALJ found Thorsett's later report the more convincing and concluded that the major contributing cause of claimant's combined condition was an injury caused by claimant's work activities on or before December 18, 1996. He wrote:

> "Compensability of the claim, in this case, is determined by medical causation. There is a split of medical opinion about whether claimant's work activities (lift and exertion while loading and unloading freight from the truck) or the pre-existing degenerative disc disease at the C5-6 level, and possibly the C4-5 level, was the major contributing cause which resulted in the disc herniation and, in turn, claimant's * * * disability and [need for] medical treatment. The reported opinions of Drs. Gardner and Duff, concurred in by Dr. Hubbard and initially Dr. Thorsett by unexplained 'check-the-box' reports, identify the major contributing cause as the pre-existing, underlying degenerative disc disease. Dr. Thorsett's later explained report identifies the major contributing cause as a 'lifting injury' associated with claimant's work at Interstate.
>
> "I defer to the reported opinions of Dr. Thorsett about causal relationship. I am persuaded, based on the facts presented at hearing, that his reported opinions are more appropriate. Claimant had fully recovered, within one or two months, from any cervical problems he may have had during 1987. Thereafter, claimant had no permanent neck or cervical residuals and no further neck problems or symptoms until December 19, 1996. X-rays taken during 1987 revealed that his cervical area was 'normal.' Claimant's work activities as a truck driver at Interstate during December 1996, involving loading and unloading merchandise from the truck required 'substantial' lift and exertion. Although no specific injury occurred, and no one time event of specific trauma could be identified, the physical activity **<161 Or App 519/520>** requiring lift and exertion during December 1996 was at least a type of repetitive microtrauma to the neck or cervical area.[1] Last, Dr. Thorsett's July 28, 1997, reported opinion about causal relationship is explained. His concurrence with the [IME] report was not explained."

The Board adopted the ALJ's conclusions without amendment.

SAIF petitioned for review, contending that "the Board applied an incorrect legal standard or otherwise erred as a matter of law in concluding that Dr. Thorsett's opinion satisfied claimant's burden of proving major contributing cause under ORS 656.005(7)(a)(B)." ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

SAIF argues that, as a matter of law, Thorsett's opinion could not satisfy claimant's burden of proving that his work-related injury was the major contributing cause of the disability or need for treatment of his combined condition. In its view, Thorsett's opinion is legally inadequate because it does not properly assess the relative contribution of the different causes of claimant's condition but, rather, attributes claimant's need for treatment to the work injury because, before the December 18 trip, claimant's degenerative disc disease had been asymptomatic for ten years.

ORS 656.005(7)(a)(B) requires an assessment of the major contributing cause, which involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. *Dietz v. Ramuda*, **<161 Or App 520/521>** 130 Or App 397, 401, 882 P2d 618 (1994), *rev dismissed* 321 Or 416 (1995). Whether a preexisting condition or an on-the-job injury is the major contributing cause of a worker's condition is the sort of complex medical question that ordinarily requires expert testimony. *See Uris v. Compensation Department*, 247 Or 420, 424-26, 427 P2d 753 (1967) (where situation is such that cause and effect relationship of accident to injury would not immediately be apparent to layperson, expert testimony is required). Hence, the Board generally must rely on evidence from medical experts to make that determination and cannot attempt to supply its own diagnosis.

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[1] Although claimant had not been able to identify a specific traumatic event that could have caused his condition, at hearing he argued that his condition was the result of an industrial accident as defined in *Valtinson v. SAIF*, 56 Or App 184, 641 P2d 598 (1982) ("sudden onset" component of definition of injury does not equate with instantaneous; injury can occur over discrete period of time).

Although work activities that precipitate a claimant's injury or disease *may* be the major contributing cause of the condition, that is not always the case. *Dietz*, 130 Or App at 401. The medical expert must take into account all contributing factors in order to determine their relative weight. At first reading, Thorsett's statement, that "the fact that [claimant] has been completely asymptomatic for many years would lead me to believe that the most likely major contributing cause to his symptoms was the lifting injury associated with his work[,]" appears to avoid that evaluation. However, the context in which the statement was made would permit the Board to conclude that Thorsett understood the necessary analysis and applied it properly.

Thorsett was responding to an inquiry by plaintiff's attorney, who had asked him to provide a diagnosis and an opinion as to "whether or not [Thorsett felt that claimant's] work activities at Interstate Distributing were in fact the major contributing cause of [claimant's] diagnosed condition." In his response, on which the ALJ relied, Thorsett provided a history of his treatment of claimant. Thorsett stated that he was aware of claimant's 1987 injury and was aware that x-rays taken in 1997 revealed some disc degeneration. He then stated that, given his understanding of claimant's condition over the last ten years, including the fact that claimant had been completely asymptomatic, he believed that claimant's work injury was the most likely major contributing cause of claimant's symptoms. We have stated that an "expert's opinion need not be ignored merely because it fails to include 'magic words.'" *Freightliner Corp. v. Arnold*, **<161 Or App 521/522>** 142 Or App 98, 105, 919 P2d 1192 (1996). In this case, given the context of Thorsett's opinion and the record as a whole, it was reasonable for the Board to interpret Thorsett's use of the word "symptoms" to mean claimant's current condition and need for treatment. Accordingly, the Board did not err in concluding that claimant's combined condition was compensable under ORS 656.005(7)(a)(B).

Affirmed.

Cite as 161 Or App 644 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lonnie Travis, Claimant.

WORLDMARK THE CLUB, Petitioner,
v.
LONNIE TRAVIS, Respondent.
(WCB 97-08466; CA A102570)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 15, 1999.
Jerald P. Keene argued the cause and filed the brief for petitioner.
R. Adian Martin argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
BREWER, J.
Affirmed.

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161 Or App 646> Employer seeks review of a Workers' Compensation Board order setting aside employer's denial of claimant's claim based on a combined low back condition. The Board determined that the combined condition was compensable because claimant's work injury was the major contributing cause of his need for treatment. ORS 656.005(7)(a)(B). We affirm.

We take the following undisputed facts from the record. ORS 656.298(7).[1] In 1970, before working for employer, claimant experienced back problems and underwent a lumbar laminectomy at L4-L5. After the surgery, claimant was essentially pain free, except for occasional flare-ups for which he obtained chiropractic care. Those flare-ups never included any radicular pain. Claimant was last treated by a chiropractor in 1989. In 1995, claimant sustained an injury to his buttocks when he fell from a truck. The pain from that injury also occasionally recurred and required treatment but never involved radicular pain.

Claimant began working for employer in 1996. In 1997, while working for employer as a housekeeper, claimant was bending over making a bed when he felt an "electric shock" and harsh pain in his back and legs. The pain caused claimant to collapse momentarily onto the bed. Claimant had never felt that type of pain before. He was able to continue his shift, but the pain was "extreme." Within a few days, claimant's right leg began to "give out."

Dr. Salmons, a chiropractor, initially treated claimant and diagnosed a lumbosacral sprain. After initial treatment, Salmons referred claimant to Dr. Fox, a medical doctor. Fox diagnosed an acute lumbar strain and a "probable ligament tear strain," took x-rays and ordered an MRI for claimant's back. Those images revealed degenerative joint disease, degenerative disc disease, a disc herniation at L4-L5, and the results of the 1970 laminectomy. Fox then referred claimant to Dr. Chestnut, a neurologist. Chestnut ordered a **<161 Or App 646/647>** CT scan that revealed mild scoliosis and degenerative disc disease. Chestnut wanted claimant to see Dr. Karasek, another neurologist, in order to locate the source of claimant's pain. Before Karasek examined claimant, employer accepted a disabling claim for a "lumbar strain."

After employer accepted the claim--but before Karasek examined him--claimant underwent an independent medical evaluation by Dr. Farris, an orthopedist. Farris diagnosed a disc herniation at L4-L5, preexisting scoliosis and degenerative disc disease, and preexisting degenerative hip arthritis. Farris suggested that claimant's problem was caused by the right hip joint instead of his lumbar spine. However, he also said that, if claimant had never experienced any radicular symptoms before the 1997 work injury, then that injury was "the major contributing cause of [the] disc herniation."

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[1] The parties accept the factual summary adopted by the Board from the opinion and order of the administrative law judge (ALJ).

Karasek then examined claimant and performed tests in an attempt to determine the origin of the pain. Karasek also reviewed Farris' report and agreed with Farris' conclusions. At that time, Karasek stated that the assessment of any causal relationship must await further diagnosis. Farris subsequently reviewed Karasek's records and issued a second opinion in which he stated that the causation issue depended on whether "[claimant] had significant problems with his low back over the years * * *."

In response to inquiries from employer's insurer, Fox also gave an opinion on the cause of claimant's current condition. Fox concluded that the work injury was the "major contributing cause of [claimant's] condition."

Based on those intervening medical opinions, employer amended its original acceptance to include a combined condition. ORS 656.005(7)(a)(B).[2] It accepted a disabling claim for the previously accepted lumbar strain combined with

> **161 Or App 648>** "preexisting noncompensable status post lumbar laminectomy, L4-L5, on the right remote; disc herniation, L4-L5, on the right; scoliosis and degenerative disc disease of the lumbar spine, pre-existing and degenerative disc arthritis of the right hip, pre-existing."

Employer then issued a denial of the combined condition on the ground that the work injury was not the "major contributing cause" of claimant's low back condition and need for treatment. Subsequently, Karasek and Chestnut rendered opinions regarding the cause of claimant's combined condition. Chestnut concluded that both the work injury and the preexisting conditions "share[d] the culpability in an unquantified and probably unquantifiable ratio." Karasek stated that he thought the work injury "was significant and the cause of [claimant's] current need for treatment." Employer subsequently closed the claim, and claimant requested a hearing seeking reversal of the denial of compensability.

The ALJ set aside employer's denial on procedural grounds. The Board affirmed the ALJ, although on different grounds. The Board analyzed the doctors' opinions regarding causation and concluded that they established that claimant's work injury was the major contributing cause of his combined condition. The Board, therefore, determined that claimant's condition was compensable. This petition for judicial review by employer followed.

We review the Board's legal conclusions for errors of law and determine whether its findings are supported by substantial evidence in the record. ORS 183.482(8)(a) and ORS 183.482(8)(c). Substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make that finding. ORS 183.482(8)(c); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990).

On review, employer initially contends that whether claimant suffered a herniated L4-5 disc is "unresolved" in the record. The Board accepted medical evidence that claimant did suffer such a herniation. That determination was supported by substantial evidence, including x-rays taken after the 1997 injury and the diagnosis of Farris, the independent medical examiner in this case. We reject employer's **<161 Or App 648/649>** suggestion that the issue of whether or not a herniated disc or similar pathology existed remains an unresolved "mystery." While, as employer argues, the medical record includes conflicting evidence on the subject, the existence of discrepancies among various doctors' opinions does not generally vitiate their evidentiary value. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Employer next asserts that the Board erred in concluding that the doctors' opinions constituted substantial evidence that the work injury was the major contributing cause of claimant's current condition or need for treatment. According to employer, those opinions were insufficient because they did not compare the contribution of the work injury with the contribution of the preexisting condition and determine which was the primary cause of the combined condition or need for treatment. On the other hand, claimant contends that those opinions constitute substantial evidence supporting the Board's conclusion.

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[2] ORS 656.005(7)(a)(B) provides:

> "If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

In order to establish the compensability of a combined condition, claimant must show that the work injury is the "major contributing cause" of his combined condition or need for treatment. ORS 656.005(7)(a)(B). In making that determination, the Board must evaluate the relative contribution of the preexisting condition and the work injury and decide which was the primary cause of the combined condition or need for treatment. *SAIF v. Nehl*, 149 Or App 309, 311-12, 942 P2d 859 (1997), *rev den* 326 Or 389 (1998); *Dietz v. Ramuda*, 130 Or App 397, 401, 882 P2d 618 (1994). Because that evaluation involves a complex medical question, the Board must generally rely on expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420, 424-26, 427 P2d 753 (1967).

Here, the Board relied on Fox's and Farris' opinions to establish that claimant's work injury was the major contributing cause of his combined condition. The Board also recognized that Karasek's opinion supported Fox's conclusions and that Chestnut could not render a definitive opinion regarding causation. For purposes of judicial review, it does not matter that not all of the doctors gave an opinion satisfying the major contributing cause standard. *Armstrong*, 90 Or **<161 Or App 649/650>** App at 206. If the Board's decision is reasonable, keeping in mind that there are doctors on both sides of a medical issue, that determination is supported by substantial evidence. *Id.* In this case, we conclude that the opinions of Fox and Farris furnish substantial evidence supporting the Board's finding, despite the existence of other inconclusive medical evidence.

When asked to give his opinion regarding causation, Fox said, "[o]n review of my records the work activity * * * was the major contributing cause of [claimant's] current condition. He did have a preexisting condition but was working unrestricted and pain free prior to the [work injury]." The Board found that opinion persuasive, because Fox was claimant's attending physician and because the opinion was well informed and based on an accurate history. Employer argues that, even though it contained "major contributing cause" language, Fox's opinion was insufficient, because Fox relied only on an increase in symptoms to determine that the work injury was the major contributing cause of claimant's current condition or need for treatment. According to employer, the most that could be reasoned from Fox's opinion was that the work injury precipitated the need for treatment.

We agree with employer that the presence of "major contributing cause" language is not dispositive. *Freightliner Corp. v. Arnold*, 142 Or App 98, 105, 919 P2d 1192 (1996) (expert testimony need not be ignored because it fails to include the "major contributing cause" language). We also agree that a medical opinion that only identifies the work injury as a precipitating cause of the condition or need for treatment is not sufficient to establish the work injury as the major contributing cause. *Nehl*, 149 Or App at 313; *Robinson v. SAIF*, 147 Or App 157, 162, 935 P2d 454 (1997). However, we must evaluate Fox's opinion in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel*, 161 Or App 516, ___ P2d ___ (1999).

Fox rendered his opinion regarding causation in response to two questions posed by employer's insurer. The insurer asked:

> "In your opinion, did the work activities combine with claimant's pre-existing condition to cause or worsen his disability or need for medical treatment? If so, can you say, to **<161 Or App 650/651>** a reasonable medical probability that the work activity was the major contributing cause of the need for treatment of the combined condition?"

Those questions asked Fox first to identify whether the work injury precipitated claimant's need for treatment and then to weigh the contribution of the work injury against claimant's preexisting condition. Given that context, it was reasonable for the Board to conclude that Fox determined that the work injury was not only the precipitating cause but was also the primary cause of the combined condition.

We turn next to Farris' opinion. Employer asserts that the only reasonable interpretation of that opinion is that Farris believed that claimant's preexisting condition was the major contributing cause of claimant's combined condition. We disagree.

Farris did determine that claimant's preexisting condition played a role in his current medical condition. However, he also concluded in his first report that, if claimant had not experienced radicular pain before the work injury, then the work injury was the major contributing cause of the herniated

disc.[3] After examining Karasek's records indicating that claimant had intermittent problems with his back since 1970, Farris issued a second report modifying his first opinion. In the second report, Farris stated that, if claimant had "significant" problems with his low back between 1970 and 1997, then the preexisting condition may be the major contributing cause of claimant's condition. The Board concluded that Farris' first report supported compensability because there was no evidence in the record that claimant had experienced radicular pain before the work injury. The Board also concluded that the second report was not particularly helpful because Farris did not explain what he meant by "significant" problems. The Board found that claimant had not previously experienced "significant" low back problems based on evidence that claimant had never experienced radicular <161 Or App 651/652> symptoms, had not had any employment restrictions relating to his back before the March 1997 injury, was not under treatment and had not experienced ongoing low back pain. While claimant had received chiropractic treatment eight years earlier, the Board was unable to conclude, without greater elaboration from Farris, that that treatment amounted to "significant" problems so as to weaken his first opinion. We conclude that the Board's interpretation of Farris' reports was reasonable. Therefore, the Board's conclusion that claimant's combined condition is compensable is supported by substantial evidence.

Affirmed.

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[3] Employer also argues that the Board could not reasonably conclude that the first report supported compensability because Farris did not state that the herniated disc was the "major contributing cause of [claimant's] treatment." As we have stated repeatedly, the absence of magic language is not dispositive. *Strubel; Freightliner.*

Cite as 161 Or App 658 (1999) July 7, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Alfonso Carranza-Romero, Claimant.

SAIF CORPORATION and HAZEL DELL ORCHARDS, Petitioners,
v.
ALFONSO CARRANZA-ROMERO, Respondent.
(97-05388; CA A101469)

Judicial Review from Workers' Compensation Board.
Argued and submitted on February 11, 1999.
David L. Runner argued the cause and filed the brief for petitioners.
Bruce D. Smith argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
PER CURIAM
Remanded for reconsideration.

*Deits, C. J., *vice* Warren, P. J., retired.

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161 Or App 659> Employer seeks review of a Workers' Compensation Board order that affirmed an award of temporary disability compensation. The Board relied on its decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996), which we subsequently reversed. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, __ P2d __ (1999). Whether our decision in Bundy will affect the determination of claimant's entitlement to temporary disability compensation is not apparent from the record before us. Consequently, we remand to the Board for reconsideration in light of our decision in Bundy.

Remanded for reconsideration.

Cite as 162 Or App 242 (1999) August 4, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lois J. Schoch, Claimant.

LOIS J. SCHOCH, Petitioner,
v.
LEUPOLD & STEVENS and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(92-09982; CA A98548)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 29, 1999.
Meagan Flynn argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison, LLP.
David O. Wilson, Senior Trial Counsel, argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler,* Judges.
KISTLER, J.
Reversed and remanded for reconsideration of attorney fees.

*Kistler, J., *vice* Warren, P.J., retired.

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162 Or App 244> The Workers' Compensation Board awarded claimant $3,000 in attorney fees for time spent successfully challenging an order of the Director of the Department of Consumer and Business Services that denied claimant's request for back surgery. This court affirmed the fee award, and the Supreme Court reversed and remanded. It held that the Board's explanation was not sufficient to determine whether the Board had acted within its discretion in setting the fee. *Schoch v. Leupold & Stevens*, 325 Or 112, 934 P2d 410 (1997). On remand, the Board offered a more detailed explanation and adhered to the $3,000 figure. On review, claimant argues that the Board abused its discretion when it awarded claimant's counsel only half that to which the time spent and his customary rate should have entitled him. We reverse and remand.

This case has a complex procedural history that arises out of two parallel proceedings claimant pursued to receive one surgery.[1] In January 1990, claimant suffered a compensable low back injury. Claimant's doctor requested authorization for surgery on February 14, 1992. Liberty, the insurer, requested review of the proposed surgery by the Director. On July 16, 1992, the Director issued his proposed and final order finding that surgery was not appropriate. Claimant asked for a hearing on July 28, 1992, arguing, among other things, that the Director had no original jurisdiction over a medical services issue involving reasonable and necessary care. On December 10, 1992, ALJ Holtan issued an opinion and order affirming the Director's order. Claimant requested review of that order.

On May 25, 1993, while claimant's challenge to the denial of her first request for surgery was pending before the Board, claimant's doctor submitted a second request for surgery. On July 12, 1993, Liberty issued a denial of claimant's current condition, disability and the need for medical treatment. Claimant filed a request for hearing on that denial, **<162 Or App 244/245>** which was held on November 9, 1993, before ALJ Podnar. Liberty orally withdrew its July 12, 1993, denial letter at closing argument but maintained its *de facto* denial of surgery, arguing that the surgery was not reasonable and necessary.

On December 3, 1993, the Board concluded that, under ORS 656.327, the Director had no jurisdiction to review claimant's first request for surgery. It accordingly vacated ALJ Holtan's December 10, 1992, order and remanded for further proceedings. In response to a letter from claimant, the Board issued an order of abatement on December 29, 1993, in order to determine whether a remand was necessary.

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[1] The two parallel proceedings are WCB 92-09982 and WCB 93-09584. There is also a third proceeding, WCB 92-16273, concerning the determination order that initially closed the claim.

On January 10, 1994, ALJ Podnar found that the second request for surgery was reasonable and necessary and set aside Liberty's denial of that request for surgery. ALJ Podnar awarded claimant's attorney an assessed fee of $10,500, which the Board reduced to $5,750.[2]

On January 12, 1994, claimant wrote to the Board, regarding the first claim for surgery, and enclosed a copy of ALJ Podnar's January 10, 1994, order, finding that the surgery was reasonable and necessary. The Board entered an order on reconsideration on January 28, 1994, remanding the case to ALJ Holtan to allow both sides to present additional evidence regarding claimant's first request for surgery.[3] Liberty wrote a letter to the Board stating that it would not appeal ALJ Podnar's January 10, 1994, order because it was no longer contesting claimant's request for surgery. In the letter, Liberty argued that ALJ Podnar's decision approving the second request for surgery rendered claimant's first request for surgery moot and asked the Board to dismiss the case arising out of that first request.

162 Or App 246> On remand, ALJ Holtan found that the original Director's order was invalid but that the substance of the medical services dispute had been rendered moot by the approval of the request for surgery in the second claim. He also denied claimant's request for attorney fees. Claimant requested review of ALJ Holtan's order on remand.

On review, the Board found that the first request for surgery was not moot and awarded claimant attorney fees of $3,000 under ORS 656.386 (1).[4] The Board's order stated:

> "After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services at hearing, on Board review and on remand concerning the validity of the Director's July 16, 1992 order is $3,000, to be paid 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 claimant's counsel might go uncompensated."

Lois J. Schoch, 47 Van Natta 71, 73 (1995). Claimant asked the Board to reconsider the amount of fees it had awarded and submitted a statement of services totaling $19,897.50. In its order on reconsideration, the Board adhered to its earlier decision. We affirmed without opinion, and the Supreme Court allowed review.

The Supreme Court reversed. The court assumed that the Board had considered all of the factors mentioned in OAR 438-015-0010(4). The problem, the court reasoned, was that the Board had failed to explain how those factors had weighed in its decision-making process. *Schoch*, 325 Or at 119. What was missing from the Board's opinion was the rationale that had led it from the factors it considered to the fee it awarded. *Id.* It was unclear to the court whether the **<162 Or App 246/247>** Board had thought that the hourly rate was too high, whether it thought that the time spent on the case was excessive, or whether the Board had discounted claimant's fee request because of the fees awarded in the parallel proceeding. *Id.* at 119-20. The court explained: "In sum, we conclude that the Board's order does not contain a sufficient explanation to permit an appellate court to review the Board's exercise of discretion in setting a reasonable attorney fee." *Id.* at 119. The court accordingly remanded the case to the Board.

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[2] The Board ordered the lower fee because claimant included a contingent multiplier of 1.5 in the fee amount requested at hearing. The Board found that it was not appropriate to consider a separate, additional contingency multiplier, because one of the factors set forth in OAR 438-15-010(4) is a contingency factor that was already taken into consideration.

[3] The Board remanded to the hearings division in light of *Jefferson v. Sam's Cafe*, 123 Or App 464, 861 P2d 359 (1993), *rev den* 320 Or 453 (1994) (the Hearings Division, not the Director, has jurisdiction to resolve disputes concerning future medical treatment).

[4] The Board awarded fees because (1) claimant initiated the appeal by requesting a hearing on the Director's July 16, 1992, order; (2) both the Director's order declaring treatment not compensable and ALJ Holtan's December 10, 1992, order affirming the Director's order constituted orders denying claimant's claim for compensation; and (3) claimant finally prevailed on the issue of compensation when the Director's order was declared null and the insurer no longer challenged the surgery claim. *See* ORS 656.386(1). Liberty has not challenged the Board's decision to award fees; only the amount of fees has been at issue.

In its order on remand, the Board reaffirmed that $3,000 is a reasonable fee. It reasoned:

> "As compared to typical medical services cases which come before us, the issues here were of average complexity. The hearing was also of average length. On the other hand, in light of the 'original/appellate jurisdiction' and '*de novo*/substantial review' aspects of this case, we consider the issues to have been of above average procedural complexity. Moreover, the nature of the proceedings was also beyond the normal case in that claimant's counsel performed services at the hearings level, on Board review, and before the Board on remand.
>
> "Considering the complicated procedural aspects of the claim, there was a decided risk that claimant's counsel's efforts might have gone uncompensated. For the same reason, expenditure of substantial time was required to secure claimant's benefits. The parties' respective counsels also presented their positions in a thorough, well-reasoned and skillful manner.
>
> "Finally, we take into consideration that claimant previously prevailed against a denial of the same surgery in a collateral proceeding for which her counsel has already been awarded a $5,750 attorney fee. In addition, claimant's counsel is not entitled to an attorney fee for services devoted to the insurer's withdrawal of its appeal from the Order on Reconsideration. Finally, no attorney fee is awardable for claimant's counsel's services at any level concerning the attorney fee issue.
>
> "After considering the aforementioned factors, we continue to conclude that $3,000 is a reasonable assessed attorney fee for claimant's counsel's services regarding the insurer's 'pre-remand hearing' concession concerning claimant's surgery. In particular, we have considered the **<162 Or App 247/248>** time devoted to the issue (as represented by the record, claimant's appellate briefs, and her counsel's statements of services), the procedural complexity of the issue, the nature of the proceedings (hearing, Board review and remand), the value of the interest involved, and the risk that claimant's counsel might go uncompensated."

Lois J. Schoch, 49 Van Natta 788, 789-90 (1997) (footnotes and citations omitted).

The Board added in a footnote:

> "In reaching this conclusion, we wish to emphasize that we are not questioning claimant's counsel's representations regarding the amount of time expended in pursuit of the insurer's eventual concession regarding claimant's surgery claim. Rather, for the reasons expressed above, particularly claimant's successful efforts in another proceeding regarding the same surgery, services which resulted in a $5,750 attorney fee award, we find $3,000 to constitute a reasonable attorney fee award in this proceeding."

Id. At 790.

On review, claimant argues that the Board abused its discretion when it reduced her fee request by more than half. She claims that nothing in the Board's order shows that either the time her counsel spent or his hourly rate was unreasonable.[5] She also argues that the fact that she had recovered $5,750 in the parallel proceeding did not justify the reduction the Board imposed. Liberty responds that the Board "subscribed to two of the possible explanations posited by [the Supreme Court's decision to justify its $3,000 fee award]: reduced hours and the attorney fee assessed in the parallel case meant that $3,000 was a sufficient award." Liberty accordingly concludes that the Board did not abuse its discretion.

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[5] Claimant sought $8,312.50 for 47.5 hours at $175 per hour for the time her counsel spent on this case up to February 2, 1994, the date of Liberty's concession regarding claimant's entitlement to surgery. *See Schoch*, 325 Or at 116 n 6. Except for .25 hours, it does not appear that any of the 47.5 hours for which claimant requested fees includes any time devoted to the insurer's withdrawal of its appeal from the order on reconsideration or the pursuit of attorney fees.

We are met at the outset with the same problem that confronted the Supreme Court earlier in this case. We cannot **<162 Or App 248/249>** tell from the Board's order how it evaluated the various factors it considered in arriving at a $3,000 fee. The Board's first opinion listed a series of factors that it considered and then stated that a reasonable fee was $3,000, without explaining the reasons that led to that conclusion. The Board's opinion on remand is not materially different. Although the Board's order on remand discusses some of the factors at greater length, it never explains the reason why those factors led it to reach the result it did.

The Board's opinion on remand discusses, for example, the nature of the work claimant's counsel performed before the Board and the complexity of the issues counsel addressed. The opinion does not go on to say, however, whether the hours claimant's counsel worked were reasonable or unreasonable in light of the nature and complexity of the work he did. The intermediate step that is missing from the Board's opinion is the reasoning that led it from the factors it considered to the amount of the attorney fee it awarded. *Drew v. PSRB*, 322 Or 491, 500, 909 P2d 1211 (1996).[6]

The Board's discussion of the fee awarded in the parallel proceeding suffers from the same defect. The Board's order states: "Finally, we take into consideration that claimant previously prevailed against a denial of the same surgery in a collateral proceeding for which her counsel has already been awarded a $5,750 attorney fee." The Board does not explain, however, why the recovery in the collateral proceeding meant that the award in this proceeding should be reduced. Perhaps the Board thought that the attorney's efforts in the two proceedings were duplicative, but it neither said nor explained why it thought so. We cannot say that it was so obvious that the attorney's efforts in the two proceedings duplicated each other that no explanation was necessary. Rather, it appears that the two proceedings were directed at different but equally legitimate goals.[7] There may **<162 Or App 249/250>** be appropriate reasons why the award in the other proceeding justified reducing the award in this one, but the Board needs to explain why that is so before we can determine whether it acted within its discretion.

The Board need not provide an elaborate or extensive explanation of its reasoning. When, however, either a claimant or an insurer submits a specific statement of services or a specific objection to a fee award, *Schoch* requires that the Board do more than simply describe the factors it has considered and then posit a reasonable fee. *See* 325 Or at 119; *compare SAIF v. Bacon*, 160 Or App 596, 604, ___ P2d ___ (1999) (discussing level of specificity necessary when no specific objection has been made). Rather, *Schoch* requires that the Board explain the reasons why the factors it considers lead to its conclusion that a specific fee is reasonable. Unless the Board explains why its consideration of the various factors caused it to agree or disagree with the specific request or objection a party has presented, we cannot say whether it acted within or abused its discretion in awarding fees. The Board's order is reversed and the case remanded for reconsideration of the attorney fee.

Reversed and remanded for reconsideration of attorney fees.

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[6] As the Supreme Court recently explained in an analogous context, an agency must do more than find facts and state conclusions. "[A]gencies are also required to demonstrate in their opinions the *reasoning* that leads the agency from the *facts* that it has found to the *conclusions* that it draws from those facts." *Drew*, 322 Or at 500 (emphasis in original).

[7] For all that we can tell from the record, it appears that the attorney's efforts in the first proceeding were directed primarily to determining who had jurisdiction to rule on the reasonableness of claimant's request for surgery while the efforts in the second proceeding were directed towards proving the reasonableness of the request for surgery.

Cite as 162 Or App 295 (1999) August 4, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas R. Sledd, Claimant.

SAIF CORPORATION and JENSEN TREE SERVICE, Petitioners,
v.
THOMAS R. SLEDD, Respondent.
(WCB 96-06662; CA A99152)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 20, 1998.
David L. Runner argued the cause and filed the brief for petitioners.
Benton Flaxel argued the cause for respondent. With him on the brief was Flaxel & Nylander.
Before Warren, Presiding Judge,* and Edmonds and Armstrong, Judges.
PER CURIAM
Remanded for reconsideration.

*Retired February 28, 1999.

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162 Or App 296> Petitioners SAIF Corporation and Jensen Tree Service seek review of a Workers' Compensation Board order that affirmed an award of temporary disability compensation for a period beginning nearly three years before it was authorized by claimant's attending physician.[1] The Board adopted and affirmed the administrative law judge's order, which was based on the Board's decision in an earlier case, *Kenneth P. Bundy*, 48 Van Natta 2501 (1996). However, this court has since reversed *Bundy*. *Fred Meyer, Inc. v. Bundy*, 159 Or App 44, 978 P2d 385, *rev pending* (1999). We remand to the Board for reconsideration in light of our decision in Bundy.

Remanded for reconsideration.

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[1] This award was limited by ORS 656.212, which places a two-year maximum on the length of time a worker can receive temporary disability compensation.

Cite as 162 Or App 325 (1999) August 11, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gerald R. Balcom, Deceased, Claimant.

SAIF CORPORATION and UNIVERSAL APPLICATORS, INC., Petitioners,
v.
JANICE BALCOM, Personal Representative of the Estate of Gerald Balcom, Deceased, Respondent, and
VF CORPORATION and JANTZEN, INC., Intervenors.
(WCB 95-09867; CA A97957)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 19, 1999.
Julene M. Quinn argued the cause for petitioners. On the brief was Michael O. Whitty.
Robert E. Nelson and Jerald Keene argued the cause for respondent. On the brief was Robert E. Nelson.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Armstrong, Judge.
ARMSTRONG, J.
Remanded with instructions to vacate order and to dismiss claimant's hearing request.

*Diets, C.J., *vice* Warren, P.J., retired.

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162 Or App 327> Petitioners seek review of an order of the Workers' Compensation Board that determined that claimant had suffered a compensable injury. Because claimant died before the final disposition of his hearing request, we remand the case to the Board with instructions to vacate its order and to dismiss claimant's hearing request.

The administrative law judge (ALJ) found the following facts, which were adopted by the Board:

"Claimant was an employee who worked long hours for the employer. He would get to work early in the morning. There were also occasions where he would work late in the evenings. He was paid a monthly salary with no overtime.

"On August 10, 1995, claimant drove his own vehicle to the employer's Portland shop. He then rode to the Salem job site with another employee.

"On August 9, 1995, claimant and his employer purchased a truck from Curly's Dairy. When they purchased the truck, they planned to sell it and share the profits. At the end of the work day on August 10, 1995, claimant had one of his employers take him to Curly's Dairy where he picked up the newly purchased truck and drove it back to Portland. He planned to drive the truck back to Portland from the Salem job site, make a few bids for jobs, leave the truck at the shop, pick up his pick-up truck and then drive home. Claimant was involved in a serious motor vehicle accident on Interstate 5 prior to getting to either a bid location or the shop.

"If claimant had not driven the Curly's Dairy truck back from the job site, he would have either ridden with his employer or driven a load of sand back to the shop.

"Claimant had planned to stop by three locations and make three bids for the employer before going home. While the bid did not always result in work for the employer, bidding was part of claimant's work and he performed the bidding in the evening at the end of the work day.

"Claimant could have taken either I-5 or I-205 back from the job site. It depended on traffic which route was fastest.

162 Or App 328> "Claimant was involved in a motor vehicle accident which occurred before he had gotten back to the shop."

Claimant filed a claim for workers' compensation benefits for the injuries that he had sustained in the accident. Petitioners denied the claim on the ground that the injuries had not occurred within the course and scope of claimant's employment. Claimant requested a hearing on the denial. After the requested hearing, the ALJ concluded that the accident had occurred while claimant was acting within the course and scope of his employment and, accordingly, that the injury was compensable.

Petitioners requested review by the Board. The Board adopted and affirmed the ALJ's order, noting that the facts of the case were analogous to those presented in *Savin Corp. v. McBride*, 134 Or App 321, 894 P2d 1261 (1995). Petitioners requested review by this court, but claimant died after the parties had briefed the case.

After claimant's death, petitioners moved for an order of default and reversal on the ground that claimant had not been survived by anyone "who would have been entitled to receive death benefits if the injury causing the disability had been fatal." ORS 656.218(5). In their view, the fact that claimant had not been survived by such person meant that there was no one who could pursue claimant's claim for benefits to a final resolution. In response, VF Corporation/Jantzen, Inc., moved to intervene or, alternatively, to appear *amicus curiae* on petitioners' motion to dismiss. We denied petitioners' motion and allowed the intervention. Claimant's ex-wife, as personal representative of his estate, also moved to be substituted as respondent, which we allowed.

Before reaching the merits, we first must consider the effect of claimant's death on the case. Claimant's ex-wife argues that she was properly substituted as a party and, therefore, can pursue the claim. Petitioners contend that ORS 656.218, which governs the effect of a claimant's death on the disposition of the claimant's hearing request, controls our authority to decide the case. We agree with petitioners.

162 Or App 329> ORS 656.218(3) provides:

> "If the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the persons described in subsection (5) of this section shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing."

ORS 656.218(5) provides, in turn:

> "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."

The persons entitled to receive death benefits as a result of a worker's death are the worker's surviving spouse, children and dependents. ORS 656.204. Claimant's ex-wife is not one of the people who is entitled to receive death benefits as a result of claimant's death, and there is no one else who is entitled to receive those benefits.

The fact that claimant's ex-wife is the personal representative of claimant's estate does not affect our conclusion. A personal representative is not included in the class of people who are entitled to pursue a claim in the event that a claimant dies before the final disposition of the claimant's hearing request.[1] *Trice v. Tektronix*, 104 Or App 461, 801 P2d 896 (1990).

Because we have decided that claimant's ex-wife is not one of the persons who can pursue a claim under ORS 656.218(3), we turn to whether the statute applies to this case. ORS 656.218(3) refers to a final disposition of a hearing request. We conclude that a final disposition of such a request occurs when a final order has been entered on it that is not subject to further review by the Board or the courts. We base our conclusion on our reading of the statute in context **<162 Or App 329/330>** with related provisions. Whether or not a decision by the Board, and, consequently, any disposition, is final is controlled by ORS 656.295(8), which provides:

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[1] No question has been raised by the parties about whether the defense of an ALJ or Board award on a claimant's hearing request constitutes "pursuit" of the matter. For purposes of this opinion, we assume that pursuit of a matter includes such a defense.

> "An order of the Board is final *unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review* pursuant to ORS 656.298. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.298."

(Emphasis added.) Thus, under that statute, a Board order is not final if one of the parties has timely sought judicial review of it. Without a final order, there can be no final disposition.

That conclusion is consistent with our decision in *Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996), which involved the retroactivity provision of Senate Bill 369. Section 66(5)(a) of Senate Bill 369 provided:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not apply to any matter for which *an order or decision has become final* on or before the effective date of this Act."

(Emphasis added.) We concluded that whether an "order or decision has become final" for purposes of section 66(5)(a) was controlled by ORS 656.295(8). Although the provision at issue in *Volk* referred to final orders, while the statute at issue here refers to final disposition, we see no meaningful distinction between them with regard to finality. Accordingly, we conclude that there has not been a final disposition of claimant's hearing request, so the request cannot go forward to final disposition without someone who is entitled under ORS 656.218 to pursue it.[2]

162 Or App 331> Because of our decision on the authority of claimant's ex-wife to pursue claimant's claim, we do not reach the merits of the parties' dispute. We remand with instructions to the Board to vacate its order and to dismiss claimant's hearing request.

Remanded with instructions to vacate order and to dismiss claimant's hearing request.

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[2] Moreover, a contrary conclusion would lead to anomalous results. Assume, for example, that final disposition of a hearing request under ORS 656.218(3) meant entry of a Board order on the request, which would allow claimant's ex-wife to pursue the claim on review to us. If we affirmed the Board's order, the amounts due claimant on the claim presumably would be paid to claimant's ex-wife as the personal representative of his estate. However, if we reversed the Board's decision on the merits and remanded it to the Board for reconsideration, there would be no one who could continue to pursue the matter on claimant's behalf on remand, because there would no longer be an existing Board order to constitute a final disposition of claimant's hearing request under ORS 656.218(3). It would make little sense to make the recovery of benefits turn on the fortuity of whether we affirmed or reversed a Board order after a claimant has died.

Cite as 162 Or App 345 (1999) August 11, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bryan M. Fitzsimmons, Claimant.

BRYAN M. FITZSIMMONS, Petitioner,
v.
ISLAND CITY STEEL and SAIF CORPORATION, Respondents.
(97-04681; CA A102936)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 5, 1999.
Adian Martin argued the cause for petitioner. On the brief was Michael A. Gilbertson.
David L. Runner argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
PER CURIAM
Affirmed.

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162 Or App 346> Claimant seeks review of an order of the Workers' Compensation Board finding that an earlier stipulation barred his claim for a ganglion cyst. Before the Board, claimant argued that the issue was whether his "ganglion cyst claim [was] barred by the issue of claim preclusion or issue preclusion." He told the Board that his claim was not barred because it was not "raised or raisable" when the ALJ accepted the stipulation.[1] The Board ruled against claimant.

In the brief that claimant filed in this court, he makes the same arguments that he pursued before the Board. At oral argument, however, he correctly acknowledged that his ganglion cyst claim was "raised or raisable" at the time the ALJ accepted the stipulation. *See Good Samaritan Hospital v. Stoddard*, 126 Or App 69, 867 P2d 543 (1994). Claimant also advanced a new interpretation of the parties' stipulation at oral argument; he argued that the parties intended to limit the claims they compromised to those claims that were either specifically accepted or denied in the stipulation. Claimant failed to preserve that issue, however. His new interpretation was neither presented to the Board nor set out in his brief to this court.

Affirmed.

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[1] Although the relationship claimant perceived between claim preclusion and the terms of the stipulation is not completely clear, he appears to have concluded before the Board that the doctrine of claim preclusion was synonymous with the phrase "raised or raisable" in the parties' stipulation.

Cite as 162 Or App 467 (1999) September 15, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Debra L. Ridenour, Claimant.

SISTERS OF PROVIDENCE and AETNA CASUALTY CO., Petitioners,
v.
DEBRA L. RIDENOUR, KLAMATH COUNTY PERSONNEL and SAIF CORPORATION, Respondents.
(95-01135, 95-00795, 94-12518; CA A99664)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 28, 1999.

Charles E. Bolen argued the cause for petitioners. With him on the brief was Hornecker, Cowling, Hassen & Heysell.

Martha J. Rodman argued the cause for respondent Debra L. Ridenour. On the brief were Robert F. Webber and Black, Chapman, Webber & Stevens.

Julene M. Quinn argued the cause and filed the brief for respondents Klamath County Personnel and SAIF Corporation.

Before Landau, Presiding Judge, and Wollheim, Judge, and Warden, Senior Judge.

LANDAU, P. J.

Affirmed.

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162 Or App 469> Sisters of Providence and its workers' compensation insurance carrier, Aetna Casualty Co. (Aetna), seek review of an order of the Workers' Compensation Board (Board) finding Aetna responsible for claimant's current low back condition and need for treatment. The Board found that Aetna had failed to rebut the presumption that, when there have been successive injuries to the same body part, the last industrial injury contributed independently to the condition. On review, Aetna contends that the Board erred in finding that claimant's successive injuries involved the same "body part." We affirm.

Claimant injured her lower back while working for Klamath County Personnel, which was insured by SAIF Corporation (SAIF). In 1987, SAIF accepted a claim for "herniated nucleus pulposus, L4-5," and claimant had surgery to remedy the condition. The claim ultimately was closed with an award for unscheduled disability.

In 1994, claimant sustained a lumbar strain while working for Sisters of Providence. Aetna accepted a nondisabling "low back muscle strain." Dr. Henderson examined claimant and eventually performed a laminectomy and a facetectomy at L4-5. Henderson explained that claimant had degenerative disc disease and that the removal of the disc at L4-5 in 1987 caused a buildup of bone, which eventually impinged on the nerve root. Henderson said that the 1994 incident "tweaked or bumped" the nerve root and caused the nerve root to swell. The laminectomy and facetectomy were required to decrease the irritation. Aetna issued a partial denial, denying the compensability of the L4-5 disc condition.

Claimant filed an aggravation claim with SAIF. Dr. James examined claimant at SAIF's request. He did not have information that was available to Henderson, but, on the basis of claimant's oral history, opined that the February 1994 injury "materially contributed to and was most likely the cause of her subsequent requirement for medical follow-up and surgery in 1994." SAIF denied responsibility for claimant's current low back condition.

162 Or App 470> Claimant requested a hearing on the denials. The ALJ upheld Aetna's denials and reversed SAIF's denials. The Board reversed. The Board reasoned that, under *Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984), there is a presumption that, where there have been successive injuries to the same body part, the last occupational injury contributed independently to the condition requiring medical treatment. The Board found that claimant had suffered successive injuries to her low back and that Aetna had failed to carry its burden of overcoming the presumption. The Board, in fact, held that the evidence in the record affirmatively established that the 1994 strain injury independently contributed to the current low back condition.

On review, Aetna argues that the Board erred in applying *Kearns*, because the injuries that claimant suffered in 1987 and 1994 did not involve the same "body part." According to Aetna, the 1987 condition involved a herniated nucleus pulposus, L4-5, while the 1994 condition involved more generally the "low back." Aetna insists that L4-5 and "low back" do not involve the same body parts. It argues that "low back" is too general a term to qualify as a body part as a matter of law. Alternatively, it argues that, to the extent that "low back" constitutes a body part, it is different from the body part involved in an injury to the L4-5 portions of the back.

In *Kearns*, we held that:

> "'Where there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in additional disability, and the employer/insurer on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation; e.g., that its accepted injury caused only symptoms of the condition or involved a different condition affecting the same body part.'"

70 Or App at 585-86 (quoting with approval Board order in that case). Whether successive injuries involved the same "body part" is a question of fact. *See Hambrick v. Weyerhaeuser Co.*, 118 Or App 81, 84, 846 P2d 426 (1993) (Board's determination of the "body part or organ" that has been disabled by occupational injury is reviewed as a question of fact). We review the Board's findings of fact for substantial evidence. ORS 183.482(8)(c); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990).[1]

Aetna cites no authority for its assertion that the law requires a certain minimum level of specificity to a "body part" for purposes of applying the *Kearns* presumption, and we are aware of none. Even if that were not the case, Aetna's contention that the "low back" is too generic a designation to be considered a body part cannot be squared with OAR 436-035-0350(2), which specifies that, for the purposes of rating disabilities, the lumbrosacral region--the low back--is considered a separate body part.

It is undisputed that L4-5 is a specific region of the low back. It is further undisputed that both the 1987 and 1994 injuries involved the low back. The medical evidence is uniform that the 1994 injury may have been different in type, but not in location, from the original 1987 injury. We conclude that substantial evidence supports the Board's findings.

Affirmed.

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[1] No party argues, and we do not address the applicability of ORS 656.308 to this case.

Cite as 162 Or App 558 (1999) September 15, 1999

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bret Claussing, Claimant.

K-MART CORPORATION, Petitioner,
v.
BRET CLAUSSING and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(WCB No. 95-04958; CA A101688)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 12, 1999.

Karen O'Kasey argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt.

Robert F. Webber argued the cause for respondent Bret Claussing. With him on the brief was Black, Chapman, Webber & Stevens.

Denise G. Fjordbeck, Assistant Attorney General, argued the cause for respondent Department of Consumer and Business Services. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.

Before De Muniz, Presiding Judge, and Haselton and Linder, Judges.

LINDER, J.

Affirmed.

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162 Or App 560> This workers' compensation case is before us for a second time. On review, K-Mart Corporation (K-Mart) disputes the Workers' Compensation Board (Board) determination that K-Mart was responsible for providing workers' compensation insurance to a janitor who was injured while cleaning one of K-Mart's buildings. We affirm.

K-Mart contracted with a sole proprietorship, Charles Pittman, dba CP Janitorial Services (CP), for janitorial services. Under the contract, CP was obligated to provide workers' compensation insurance for its employees. CP failed to do so, either before or after work on the contract began. After claimant was injured, he filed a workers' compensation claim against K-Mart as the employer responsible for the claim. K-Mart disputed its responsibility and lost on that issue before the Board.

On K-Mart's first petition to this court, the parties disputed whether claimant was performing labor that was a "normal and customary part or process of K-Mart's trade or business," which is necessary before responsibility can attach to K-Mart under ORS 656.029(1). *See generally Clausing v. K-Mart Corporation*, 144 Or App 552, 926 P2d 337 (1996). We remanded the case to the Board to reconsider its determination in light of a Department of Consumer and Business Services administrative rule bearing on the question. *Id.* at 554. On remand, the Board again found that CP's janitorial services were a normal and customary part or process of K-Mart's business and, consequently, that K-Mart was the responsible employer under ORS 656.029(1). The Board further rejected K-Mart's contention that subsection (2) of the statute operated to shift responsibility back to CP because of its status as a sole proprietorship employing subject employees.

On its second petition for review, K-Mart challenges only the Board's conclusion that responsibility did not shift back to CP under ORS 656.029(2), which is an issue that turns on the statute's meaning. We review for legal correctness. *See* ORS 183.482(8)(a). Our analysis begins with subsection (1) of ORS 656.029, which provides:

> **162 Or App 561>** "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences."

As we have previously held, that subsection's plain terms impose responsibility for providing workers' compensation coverage on the person who awards the contract (here, K-Mart), unless the individual contracting to provide the labor (here, CP) provides such coverage before the contract commences. *Liberty Northwest Ins. Corp. v. Hegerberg*, 118 Or App 282, 286, 846 P2d 1216 (1993); *Nelander v. Dept. of Ins. and Finance*, 112 Or App 419, 422, 829 P2d 1048 (1992); *Wood v. Dunn*, 109 Or App 204, 211, 818 P2d 979 (1991). If that were the only statutory provision in issue, there would be no real question as to K-Mart's responsibility. Although CP was obligated by its contract with K-Mart to provide coverage, CP failed to do so before the contract commenced. ORS 656.029(1) places responsibility for providing coverage on K-Mart in that circumstance.

K-Mart's argument, however, rests on subsection (2) of ORS 656.029, which it views as "limiting" the application of subsection (1). ORS 656.029(2) provides, in pertinent part:

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

ORS 656.027, in turn, declares that "[a]ll workers are subject to this chapter except those nonsubject workers described" by the statute's other provisions. The net effect of that structure is that ORS 656.027 makes all *workers* subject to the protections of the workers' compensation insurance laws unless a worker falls into one of the limited categories of "nonsubject" workers. One such nonsubject worker is a "sole proprietor." *See* ORS 656.027(7)(a).

162 Or App 562> From that scheme, K-Mart argues that it is not the employer responsible for providing workers' compensation insurance coverage for the CP employees performing K-Mart's janitorial services under the contract. K-Mart uses the following reasoning: (1) CP was a sole proprietorship; (2) CP therefore was a nonsubject worker under ORS 656.027; (3) CP hired subject workers to provide the janitorial services that it contracted with K-Mart to provide; and (4) thus, ORS 656.029(2) places responsibility for providing coverage for those workers on CP, not on K-Mart.

The Board found the flaw in that reasoning to be K-Mart's threshold assertion that it is exempt under ORS 656.027, which is the second link in its reasoning. We agree. The exemption under ORS 656.027 is for *workers*, not for those who employ workers. Furthermore, the exemption is for *coverage*, not for responsibility to provide coverage. As the Board reasoned:

> "[E]xemptions from coverage under ORS 656.027 result from a person's *employee* classification. That is, ORS 656.027 defines those *workers* not subject to the Act. After all, every employer employing one or more subject workers in the state is subject to the Act. ORS 656.023. Thus, when ORS 656.029(2) refers to a 'person to whom the contract is awarded is exempt from coverage under ORS 656.027,' it is referring to a person in the status of a *exempt worker*. Further, when ORS 656.027(7) refers to 'sole proprietors' as being exempt, the statute is referring to 'sole proprietors' in the capacity of (or in the status as) a worker."

(Emphasis in original.)

The Board's analysis tracks the plain language of the statutes. If a person who contracts to perform services is himself or herself an exempt worker, then that person is responsible for providing coverage to any subject (that is, nonexempt) workers that he or she may hire to perform that same work. Thus, in this context, if the agreement between CP and K-Mart had been for Pittman, as a sole proprietor who was also an independent contractor, *personally* to provide janitorial services to K-Mart, CP would have been exempt from coverage under ORS 656.027(7)(a), and K-Mart **<162 Or App 562/563>** would have had no responsibility to provide coverage for Pittman under ORS 656.029(1). In that circumstance, if CP then had hired others to provide the labor, CP would have responsibility under ORS 656.029(2) for providing coverage for those individuals unless they were otherwise exempt. That is not what happened in this case, however. The Board found (and K-Mart does not dispute) that K-Mart contracted with CP in its capacity as a subject *employer* with the expectation that CP would hire employees to provide janitorial services to K-Mart. Legally, then, CP did not come within the terms of

ORS 656.029(2). That is, CP was not a person "exempt from coverage" and responsibility for providing coverage to the employees providing janitorial services for K-Mart. The Board correctly determined that K-Mart, as the person awarding the contract, was responsible for providing coverage to claimant under ORS 656.029(1).[1]

The only other issue that K-Mart raises on review is whether the Board, by reexamining its determination under the statute as well as under the administrative rule, exceeded the scope of our remand and therefore acted beyond its authority. The Board did not err in that regard.

Affirmed.

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[1] Our understanding of how subsections (1) and (2) of ORS 656.029 relate to each other is consistent with the department's administrative rule. OAR 436-050-0040 provides, in part:

> "(1)(a) When a person awards a contract, that person is responsible for providing workers' compensation coverage on all individuals performing labor under the contract if the labor under the contract is a normal and customary part or process of that person's trade or business; unless:
>
> "(A) The individuals performing labor under the contract are exempt as nonsubject workers under ORS 656.027;
>
> "* * * * *
>
> "(2) If a person awards a contract to a person who is exempt under ORS 656.027 *to perform labor under the contract without the assistance of others and that person engages subject workers to meet the conditions of the contract, the person to whom the contract was awarded becomes a subject employer and must provide workers' compensation insurance for those subject workers.* If such coverage is not provided, such person would be a noncomplying employer."

(Emphasis added.)

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